				For State Ragistrar	State of N	/larylan	-	rtment of F				giene	005	35001
				Decedent's Name (First, Middle,	Last)						2. Date of Dea	ıth	Voor	3. Time of Death
		Physici /Medic		SYLVIA THORN	TON DAN	HELS				•	Month COBE	Day 28	2005	9:30 PM
	W. Carlo	Examin		4a. Facility Name (If not institution,		_	,	4b. City, Town, o				4c. Co	ounty of Death	
				ST - AGNES  5. Social Security Number	HEALTH Sex 7.		last birthday)	BALTII If Under 1 Year	If Under		. Date of Birth	n	N A	place (State or Foreign
		Funeral Director		219.22.4532	1□M 2 <b>™</b> F	76	Yrs.	Months Days	Hours	Min.	(Month, Day 0 - 21 - 19	, Year)	Cou	NC NC
		pu ,		Usual Residence of Decedent  10a. State 10b. County		10c Cit	ty, Town or Lo	nation						10d. Inside City Limits
		Aaryla Febov	ō	MD N	١		MIMOR							1 <b>Ø</b> Yes 2 □ No
		ith the Marylan or 28a-f ehow	rect	10e. Street and Number	1.,	ער	LITTION	10f. Zip Code				10g. Citizer	n of What Cou	ntry?
		23a o	ai D	3702 COLBORNE	ROAD			2122	29				USA	
		items in	Funeral Director	11. Marital Status	12. Was Decede Armed Force	s?	.S. 13. V	Vas Decedent of H Yes, specify Cubi	lispanic Ori an, Mexicar	igin? (Spec n, Puerto Ri	fy Yes or No- can, etc.)	14.	Race - Ameri Black, White,	
	36	irs aft		1 ☐ Never Married 2 ☐ Marrie 3 🔀 Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 If Yes, Give Year or Date:		1	☐ Yes 2 <b>%</b> No	Specify:	:		St	pecify: BLA	CK
	21215-0036	d within 72 hours piene. r then "natural", irs Madical Ext	Completed by	15. Decedent's (Specify only highest			16a. Deced	lent's Usual Occup	ation	at of working	,	16b. Kind	of Business/Ir	ndustry
	121	within ne.	mple	Elementary/Secondary (0-12)	College (1-40	or 5+)	life. L	DO NOT use retire	d)			orre	10101 0	PARILATE
	d 2	e filed within Hygiene. other then	e Co	17. Father's Name (First, Middle, La	N A		MACE	TIME OPE			First, Middle,			RODUCTS
	lan	should be filled within 72 hours after death with the Maryland nd Mental Hyglene. In marked other then "naturei", or items 23a or 28a-f ehow marked other then "naturei", or items 23a or 28a-f ehow marked other then "nature".	To B	VERNON L. THOR	INTON				REBE	ECCA	WHITE	5		
	Maryland	ges 1 and 2 should be filled tof Health and Mental Hyg if item 27 ie marked othe or other treumatic event,		19a. Informant's Name/Relationshi	10	\		g Address (Street			-		own, State, Zij	Code)
		1 and 1ealth em 27 ther tr		WARREN SMITT 20a. Method of Disposition	1 (30N	-		UEDGEW sition (Name of	100D	RD,	BALTO		tion - City or T	own State
	Baltimore,	permit. Pages in Department of Himportant: if ite any injury or ot once.		1  Burial 2  Cremation 3 4  Donation 5  Other (Spe		te C	cemetery, cren	FOREST	· 1	11.03.				LS MD
	altir	permit. P Departme importan any injur		21. Signature of Funeral Service Li		un								
	8	Depa impo any i		Vanghin	()+		56	. Name and Addre UGHN C. 51 BALTO, N	JATL' F	PIKE, E	BALIO.	ND 21	229	
	1			23a. Part1. Entecthe disease, or c shock, or heart failure. List o	omplications that caus nly one cause on each	sed the deat n line.	th. Do not ent	er the mode of dyn	ng, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Ogset and Death
4	1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a		MONIA	<del>)</del> ,						DAYS.
	42	Examiner			Due to (or	as a consec	quence or):							YEARS.
		P #	ner	Sequentially list conditions, if any, leading to limited accuse. Enter Underlying Cause (Disease or injury	Due to (or	ae a conesc	quantoa of):							
,	1	cate be executed physicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to /or	as a consec	nuence of):							
	68760,	sicien buria	dicai E		d									
+			fedic											
SYLVIA	Box	Physicien: The law requires that the death certificate has been signed by the attending this certificate has been signed by the attending ral director, page 2 should be detached for use as	ician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor 1 ☐ Live birth	2 Feta	aldeath 3	Ectopic pregnanc	y			230	d. Date of deliv Month	ery Day Year
7	0	at the des by the a tached f	Physic	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4□Pregnan 9□Unknown		death 5	Other (specify) _						,
S	s, G	res that I	by Ph	Part II. Other significant condition	s contributing to deat	h but not res	sulting in the u	nderlying cause giv	ven in Part	I.	23e. Did to	obacco use	contribute to	the cause of death?
	rds	w require been sig should b									101	/es 2□	No 3 Pro	bably 4 Unknown
MANIELS	Vital Record	alawr has be e 2 sh	Completed				<del></del>				24a. Was autop	SV	prior to co	opsy lindings available ompletion of cause of
2	al B	hysicien: The law his certificate has t I director, page 2 s	-								1 ☐ Yes		death? 1 🗌 Yes	2 1 No
¥		/siciel s certil directo	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 1 Inp	atient 2	ER/Outpatier	t 3 DOA Ott	200		Check only o		□Other (Spec	ifu)
-	n of	ding Ph) h. After thi funeral c	<del> </del>	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of I		28b. Time of				3d. Describe h			• • • • • • • • • • • • • • • • • • • •
	sion	or Attending offer death. Director: After in by the fune	catic	2 Accident investigations 3 Suicide 6 Could no	tion			M 1	Yes 2					
	Division	or Attendi efter death Director: A I in by the fu	Certification;	4 Homicide determin	289. Place of	Injury - At h etc. (Speci	nome, larm, str ify)	eet, lactory, office		28	City or Tox		Number or Hui	al Route Number,
	_	To the Hospital of within 24 hours of To the Funeral D completely filled in		29a. Certifier 1 Certifying	Physicien: To the be xeminer: On the basi	st ol my kn	owledge, deatl	occurred at the tr	me, date a	nd place, ar	nd due to the	cause(s) a	nd manner as	stated.
		the H hin 24 the F nplete	Medical	one)	and manner	stated.	ation and/or in	29c. Licens		a(II occure				
		T wit	-	29b. Signature and title of certifier	MUNOTA	AV	Azali I	AD P	171	10		A 7-0	signed (Month	20 2
		1		30. Name and address of person w	no completed cause	ol death (Ite	m 23a) (Type	Print)	-(70	U		ull	יאעוטיי	o o oxcos
		15		MUETAZA KAZA	u, hud s	7 AGN	ves thos	PITAL 9	00 CA7	(ON A	ve, B	ALTIN	love, N	W 21229.
	*	Sta Regist		31. Date filed (Month, Day, Year)	327 Reg	istrar's Sign	ature And	will !						us 212,19.
		negist	rel	7019 1	2000	ياند مسالية	Sign							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien [ ] 5 1 = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year :40 am adie 8 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ridge 5. Social Security Number VIIIe. arro If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Yrs. Director 219.18.8745 12.23.1917 MD Usual Residence of Deceden the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show item 27 is marked other then "natural", or itams 23a or 28a-f shov other traumatic event, the Neulcal Examinar must be excitibed at 1 Yes 2 No Director MD HOWARD EUKRIDGE 10e. Street and Number 10g. Citizen of What Country? ould be filed within 72 hours after death with Mental Hygiene. 6437 MEADOWRIDGE ROAD 21075 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 € No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK 3 Midowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 TH GRADE DOMESTIC HOMEMAKER NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be 1 Department of Health and Mental Importaint: If item 27 is marked ott any injury or other traumatic even 2006. Be 0 JAMES EDWARD SNELL SADIE JACKSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KAREN MANNING (DAUGHTER 9524 EARL LEVY CT., LAUREL mo 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

■ Burial 2 □ Cremation 3 □ Removal from State MEADOWRIDGE 10.29.05 EURIDGE, MD ¹ 4 □ Donation 5 □ Other (Specify) 21. Signative of Funetal Service License 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE Vangh 5151 BAUD. NATU PIKE, BAUD. MO 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherascharofie Colory Vischer Wise-12 **Physician** Y-2-15 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) the attending physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Temen for 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has autopsy performed 1 Yes 2 No Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 Tes 2 No within 24 hours after death To the Funerel Director: in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dave Year) Pout J. Man, MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carlo Doise Reinfauton short 6. Mais 114 Briness 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 3 1 2005 Registrar

Indelible Ink. Ensure All Copies Are Legible. Please Type or Print in Black Indelible Ink. Ensure All Copies Are I Amend item / per th 8848 10-31-05 vt.
State of Maryland / Department of Health and Mental Hygiene State Amend Item 24a per verb., G848 10/28/05 dbb.
Registrar Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Oct 18, **Physician** 2005 12:11 PM Gibbons John Lloyd /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's 9406 Chestnut Pk St. <u>Capitol Heights</u> Birthplace (State or Foreign Country) If Under 1 Year if Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months **X**X M 2□ F 53 Yrs 579 76 5549 1952 Jan 26, Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State st than "naturel", or Items 23a or 28a-f show . The Madical Extra Ther coust be notified at 1 Yes 2 XX George's Capitol Heights Prince Director Maryland 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number 9406 Chestnut PK St. 20743 <u>United States</u> Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ☐Yes Ə∏ No fYes, Give A Never Married 2 Married 1 ☐ Yes 217 No Baltimore, Maryland 21215-0036 Specify. Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) other than Census Bureau Government Ith and Mental Hygid 27 is marked other r treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jean Summers Charles Gibbons 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charles Gibbons 2740 hidden Valley Road, Accokeek, MD 20607 (Brother) Health of Health other tre 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition perrit. Pages 1 Depertment of H Importent: If Ite any injury or ot once. 1 ☐ Burial XX Cremation 3 ☐ Removal from State Lee Crematory Oct20. 2005 Clinton, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Sign tu e Funeral Service Licensee noc Alexandria Ferry Road, Clinton, MD 20735 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final chorone Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner DACKETE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of) Examine ed by the attending physician and detached for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes XXNo To the Hospital or Attending Physicien: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home Hospital: 5 Residence 6 □Other (Specify) 2 ER/Outpatient 3 DOA 1 Xes 2 No 1 Inpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Marylen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 068 ieldsen omas 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar Done OCT 2 8 2005

DHMH 17 Rev 1/2001

ORIGINAL

Donna Ruth Head Amend item#4a, perME, G848, 10-31-05 TT State of Maryland / Department of Health and Mental Hygiene 05-07193 1 - For State Registrar Certificate of Death Reg No.U 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Donna Head /Medical 24 October 2005 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 110 North Hilltop Road Catonsville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Funeral Birthplace (State or Foreign Country) 1 ☐ M 2 😿 F 53 Director 214-64-3116 Yrs. Sept 13,1952 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Directo 1 ☐ Yes 2 ☑ No Maryland Baltimore Catonsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 N. Hilltop Road iteme 23a 21228 by Funerai USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of the of Health and Mental Hygiene. Int: If item 27 is marked other then "natural", or ite: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Never Worked 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) George C. Head Ruth Hess 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Head 11 N. Hilltop Road; Catonsville, Maryland 21228 Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
important: If ite
eny injury or ot 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10/28/2005 Mt. Comfort Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furieral Service Licensee 22, Name and Address of Facility Sterling Ashton Schwab Funeral Home, Inc. 100 736 Edmondson Avenue;Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** INTRACRANIAL HEMORRHAGE /Medical Due to (or as a consequence of): Examiner BERRY ANEURYSM RUPTURED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physicien and for use as tha burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Æ Unknown page 2 s 24b. Were autopsy findings available prior to completion of cause of death?

1 Xyes 2 \( \bigcap \) No 24a. Was an 1 Yes 2 No Physician: ierai Director: After this certific filled in by the funaral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Residence Specify) Scene ٩ MYes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 24 hours after death.

Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

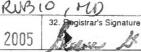
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one)

completely within 2

> State Registrar

31. Date filed (Month, Day, Year) 2005

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street

29c. License number

OCME

29d. Date signed (Month, Day, Year)

October 25, 2005

Baltimore, Maryland 21201

		•	For State Ragistrar	State o	f Marylar		artment of F		d Mental Hy	giene Reg. No.	005	35005
	Physici	an	Decedent's Name (First, Middle						2. Date of De	aath Day	Year	3. Time of Death
	/Medic	al	FANNIC JOH, 4a. Facility Name (If not institution	New stand and sur	nhor)		4b. City, Town, o	-1	Octob		305	8.30 AM.
H	Examin	er	HARBUR SIDE	Antonil	Cord	6.15	Baltima		Hairi	40.0	ounty of Death	
Ε	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	-		If Under 24	Hrs. 8. Date of Bir Min. Month, Da	rth	9. Birth	place (State or Foreign
	Director		212 22 5888	1□M 2 <b>M</b> F	93	Yrs.	Months Days	Hours	Splembe	ce 12/1	912 V	A.
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or L	ocation					10d. Inside City Limits
	Mary a-f sh	ţoţ	M.D N	la	-	BAltin	1672 6					1 2 ¥65 2 □ No
	ith the	Jirec	10e. Street and Number				10f. Zip Code			-	on of What Cou	ntry?
	s 23s	ral	2614 K. ChAS				213				15 A.	
036	within 72 hours after deeth with the Maryland ene.  Presentation (tems 23e or 28e-f show the Medical Examitment count be multised at	by Funeral Director	11. Marital Status  1 Never Married 2 Mar  3 Nover 4 Divorced	ried Armed Fo	212 No	.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	lispanic Origin an, Mexican, P Specify:	? (Specify Yes or No ruerto Rican, etc.)		Black, White,	
5-0036	n 72 hours "natural", police Exp	Completed	15. Deceder	it's Education st grade completed)		16a. Dece	edent's Usual Occup	ation	working	16b. Kind	of Business/Ir	
2	d within 72 ho piene. r than "natur I're Medicel	mple	Elementary/Secondary (0-12)	College (1	-4or 5+)		e kind of work done DO NOT use retired		WORKING		, .	
N	e filed w Il Hygiei other ti /ent, In		17. Faylier's Name (First, Middle,	(ast)		JUN	185410 CM	UKKEA 18 Mother's	Name (First, Middle	Maiden S		RK/C
land	e d fa	o Be	Nouis Bolder	2831/				Queer		i, maiosii si Iden	umame)	
ar Z	shound Mind Mind Mind Mind	F	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mail	ing Address (Street		r Rural Route Numb		Town, State, Zi	o Code)
	and 2 alth ar		Walter Juhr	1502		55	5 NEW :	PETERSh	urg AVE	BAH	MURE, MI	21022
altimore,	Pages 1 and nent of Healt int; if item 2 iry or other		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation	3 □Removal from	20b. I	Place of Disp cemetery, cre	osition (Name of ematory or other place	ce)	Date	20c. Loca	ation - City or T	own, State
	permit. Pag Department Important; I any injury o		• 4 □ Donation 5 □ Other (S	Specify)	1	Cirily .	CEMEting	K/s	BEAS SUI	BA	HIMORE /	MD
Ba	Depar Depar Impor any irr		21. Signature of Funeral Service	~		2	22. Name and Addre	ss of Facility	BEHS SUI	nerpl	Home	10
	/ Lavi		23a. Part1. Enter the disease, o	r complications that c	aused the dea	th. Do not er					1) 2121	Approximate
	Physician		shock, or heart failure. List Immediate Cause (Final disease or condition	All the second s	EUM	1016	+					Interval Between Onset and Death
	/Medical		resulting in death)		or as a consec							00000
	Examiner		Sequentially list conditions,	b. Dura to	,							
1	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		or as a consec	(uerice or):						
<u>,</u>	ate be executed hysician and the burial-transit	Examine	that initiated events resulting in death) Last	c	or as a consec	quence of):						
8760	ate be hysicia the bur	dicai		d								
39 ×	entifica ling ph e as ti		IF FEMALE:									
Вох	The law requires that the death certific te has been signed by the attending p.	Physician/Me	23b. Was decedent pregnant in the past 12 months?		come of pregn irth 2 ☐ Feta ant at time of o	al death 3	□Ectopic pregnancy	1		23	<li>d. Date of delive Month</li>	ery Day Year
o.	at the de by the a tached	yslo	1 □ Yes 2 □ No 9 □ Unknown	9□ Unkno		ieain 5	Other (specify) _					
ري ص	es that igned b be deta	by Pt	Part II. Other significant conditi	ons contributing to de	eath but not res	sulting in the	underlying cause giv	en in Part I.	23e. Did	tobacco use	contribute to t	the cause of death?
ords	w require been sig should b		DEMER	TIA					1	Yes 2 🗗	No 3□Pro	bably 4 □Unknown
မင္ပ	law re	Completed							24a. Was		24b. Were auto	opsy findings available ompletion of cause of
		Con							perfo	2 No	death? 1 ☐ Yes	2□ No
Vital Records,	sician: Th certificate irector, pag	o Be	25. Was case referred to medica examiner?	Hospital:		1==:-	Oth		Death (Check only			y a
ot	Physical dispersion	1	1 ☐ Yes 2 ☐ ¥6 27. Manner of Death	28a. Date	of Injury	28b. Time		y at	ng Home 5 Resi			fy)
0	tending F leath. tor: After the funera	atlo	1; Natural 5 ☐ Pendi 2 ☐ Accident invest	ng (Moni igation	th, Day Year)	Injury		k? Yes 2 □ No				
Division of	of or Atteracter destruction of in by the	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. Place	of Injury - At h ng, etc. (Speci	ome, farm, si fy)	treet, factory, office		28f. Location ( City or To		Number or Run	al Route Number,
	To the Hospitel or Attending Physician: which 24 hours after deals as a first deal to the Funerel Director. After this certification will be the funeral director. It is a fine to the funeral director.	edical C	29a. Certifier (Check only one) Certifyi	ng Physician: To the Examinar: On the b	best of my knoasis of examination	owledge, dea ation and/or i	th occurred at the tir nvestigation, in my o	me, date and popinion, death of	place, and due to the occurred at the time,	cause(s) a date and p	nd manner as s lace, and due t	stated. o the cause(s)
	To the To the Comp	M	29b. Signature and title of certific	er P			29c. Licens				signed (Month,	
			> WHICAS (	M-1).			DO	0584	-57 (	CTUB	SER Z	5 2005
	5		30. Name and address of person		e of death (Ite		, Print)	F7 (	MTIMOR	F 1	. 1	261
	Sta	ite	31. Date filed (Month, Day, Year		egistrar's Sign		WSIKE		11 (11100)2	<u> </u>	ر مر	
	Registi		ост 3	2005	2-0	H	Carto o					
DH	/IH 17 Rev 1/2	001		The state of the s		~ 19	A.I.					
						ORIGIN	AL					

			1 - For State Registrar		State of Ma	iryland / Depa <i>Cei</i>	artment of F rtificate of a			ene2 () () 5	35006
	Dhysisi			ne (First, Middle, La.	st)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic				ENKINS, JR					29, 2005	08:50 AM
	Examin	er		(If not institution, give HOSPITAL	e street and number)		BALTIMOR	r Location of Death		4c. County of Dea	ith
	Funeral		5. Social Security I	Number 6. S		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Bir	thplace (State or Foreign
Ì.	Director		214.40.2 Usual Residence		∏M 2□F XX	63 Yrs.	Worth's Days	Tiours Willi.	APRIL 6,		MD
	yland 10w		10a. State	10b. County		10c. City, Town or Lo	cation		<del></del>		10d. Inside City Limits
	e Mar	ctor	MD	ANNE AR	UNDEL	PASADENA					1 ☐ Yes 2☐ No
	or 28	Director	10e. Street and Nu				10f. Zip Code		10g	. Citizen of What C	ountry?
	ufter death with the Maryland ir Items 23a or 28a-f show it at innat be recitified at	Funeral	248 NOR'	TH CAROLI	NA AVE.	ever in IIS 13 V	21122	lispanic Origin? (Sp.	acity Vos or No-	USA 14. Race - Am	orion Indian
0000	after or Ite	by Fun		ried <b>XX</b> Married 4 □ Divorced	Armed Forces? 1 ☐ Yes <b>XX</b> N If Yes, Give Year or Dates:	0	f Yes, specify Cuba 1 ☐ Yes 2☐ No XX	lispanic Origin? (Span, Mexican, Puerto Specify:	Rican, etc.)	Black, Whi	
5	n 72 hours a "natural", c		(Spa	15. Decedent's Ed	ducation			ation during most of work	16	b. Kind of Business	
7	d within giene. rr than "	Completed	Elementary/Sec	ondary (0-12)	College (1-4or 5	+) life. L	DO NOT use retired	d)			
7	illed v Hygie other t	e Co	17. Father's Name	(First, Middle, Last)	2	<u>E</u>	NGINEER	18. Mother's Name	(First, Middle, Ma		NICATIONS
a	e d at b	o B	HERBERT	ROBERT J	ENKINS, SR	•		DOROTHY	HIRSCH	,	
ary	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		19a. Informant's N	lame/Relationship (	Type, Print)	19b. Mailin	g Address (Street	and Number or Rura	al Route Number, C	City or Town, State,	Zip Code)
Σ Δ	and 27 m 27 her tra			JENKINS	WIFE			ROLINA AVI			
201	9° = 5		20a. Method of Dis	☐Cremation 3 ☐	Removal from State		natory`or other plac	(e)	Date 20	c. Location - City or	Town, State
	nit. Pa partmen ortant: njury			5 □ Other (Specify uneral Service Liver		CEDAR HI				ALTIMORE,	MD
מ	permit. Departiment imports any nj		A A	RECKRY XI	1 hack			ss of Facility RAL HOME, HWY SW GI		E. MD 210	61
	Physician /Medical Examiner	9	Immediate Calse disease or condition resulting in death)	(Final on	b. Brancho	consequence of):	er the mode of dyin Ventus Thr		or respiratory arrest	ionary Embel	Approximate Interval Between Onset and Death
,00/00	tificate be executed g physician and as the burial-transit	edicai Examiner	Sequentially list or if any, leading to in cause. Enter Under Cause (Disease on that initiated event resulting in death)	S	c. Priminio	is onsequence of):	e Respira	lory Dist	1154 Syne	lrome	14-15 dys >2 months
CO. DOX OC	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours alter death.  To the Funeatal Director: After this certificate has been signed by the attending pi completely filled in by the funeral director, page 2 should be detached for use as it.	Physician/Med	IF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknowr	? months? □ No	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
cords, 1	equires thaten signed	by	Part II. Other signi	nary -ra	ontributing to death but	t not resulting in the ur	ndertying cause give	en in Part I.	23e. Did tobac		o the cause of death?
ב ב	The law rate has be page 2 sh	Completed							24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
\ \ \ \	ician: certific	Be	25. Was case reference examiner?	/	Hospital:		Oth	26. Place of Death	(Check only one)		
5	Phys	. To	1 Yes 2	No th	28a. Date of Injur	/ 28b. Time of	28c. Injury	4 □ Nursing Hor	me 5 Residence 28d. Describe how		cify)
200	ath. r: Afte	ation	1 ☐ Natural 2 ☐ Accident	5 Pending investigation	(Month, Day	Year) Injury	Work	k? Yes 2□No			
	To the Hospital or Attending Physician: which 24 hours after deals after deals. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	3 🔲 Suicide 4 🔲 Homicide	6 Could not be determined	28e. Place of Inju building, etc	ry - At home, farm, stre (Specify)	eet, factory, office		28f. Location (Stree City or Town, S	t and Number or Ru tate)	ural Route Number,
	the Hospi in 24 hour the Funer pletely fill	Medical	29a. Certifier (Check only one)	Certifying Ph	niner: On the basis of and manner stat	/	estigation, in my or	pinion, death occurre	ed at the time, date	and place, and due	to the cause(s)
	with To 1	2	29b. Signature and	this of certifier	1 Soft	mp	29c. License	0565	29d.	Date signed (Mont)	h, Dev Year)
			30. Name and add	ress of person who	completed cause of de	ath (Item 23a) (Type, I	Print)	Hanover	x. 2/1	imare Mi	1 31225
¥	Sta Registr		31. Date filed (Mor		32. R. Sistra	ath (Item 23a) (Type, I	bode		71196	TOTAL STATE OF THE	S 4 16711 A

		•	For State Registrar	State of I	Maryland /	Depa		t of H	ealth a		ental Hyg		0.05	35007
	Physici		1. Decedent's Name (First, Middle, Las	James							2. Date of Deat Month October	h	2005	3. Time of Death 7:50 P M
	/Medic Examin		4a. Facility Name (If not institution, give Ivy Hall Geriatr		-				Location o			4c. C	ounty of Dee Baltin	th
被	Funeral Director		5. Social Security Number 212-03-1875  Usual Residence of Decedent	9x □ M 2√F 7.	Age (In yrs. last	birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, Feb. 11	Year) , 19	9. Bir Co 17 Ma	thplace (State or Foreign ountry) LYLANd
	a-f show	ctor	10a. State 10b. County  Maryland Baltim	ore	10c. City, To	own or La		ıltin	nore		.,			10d. Inside City Limits 1 Yes 2 No
	ath with the 23a or 28	rai Director	10e. Street and Number 17 Fuller Aven	ue			10f. Zip		206		1	-	on of What Co	ountry?
980	hours after death with the Maryland tursi', or items 23a or 28a-1 show al Exercites frouti be notitied at	Completed by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 🖄 Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	s? X No		Was Deced f Yes, spec 1 \( \text{Yes} \) 2		spanic Orig n, Mexican, Specify:	jin? (Spe , Puerto f	cify Yes or No- Rican, etc.)		Black, Whit	erican Indian, de, etc. Ihite
Maryland 21215-0036	within 72 iene. than "nai	ompleted	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 8th Grade	lucation de completed) College (1-4		(Give life.	dent's Usua kind of wor DO NOT us	k done d e retired)	uring most	of workir	ng		of Business	•
yland 2	ld be filed ental Hyg ked othe ic event,	To Be C	17. Father's Name (First, Middle, Last) Stephen Tymin						18. Mother	gie	(First, Middle, M Behja	Maiden Si	umame)	
	s 1 and 2 shoul if Health and Me item 27 is mark other traumati		19a. Informant's Name/Relationship (Mrs. Agnes Reimer 20a. Method of Disposition		r)	17 F		Ave		Balt	I Route Number,	MD	21206	
Baltimore,	permit. Pages Department of t important: If Its any injury or of		1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Liger	1)	te ceme	atery, crer LAWN 22	natory or of Cemet . Name and	ther place CCTY d Address	s of Facility	0/27 Schi		Balt	al Hon	Maryland 1es
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a		o not ent	er the mode	of dying	, such as o	cardiac o		•	21230	Approximate Interval Between Onset and Death
760, <	be executed ician and burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequent									1)
Box 68	The law requires that the death certificate ate has been signed by the attending physoage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2 ☐ Fetal dea t at time of death		Ectopic pre					23	d. Date of de Month	livery Day Year
rds, P.O.	w requires that the bear signed by should be detact	by	Part II. Other significant conditions of	ontributing to deat		g in the u	7	iuse give				acco use		o the cause of death?
Vital Records,		Completed									24a. Was an autops perform	v	prior to death?	utopsy findings available completion of cause of
Vit	ysicien: is certifical director, p	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital: 1 □ Inp	atient 2□ER/	Outpatien	it 3 DO	A Othe	-		(Check only only only only only only only only	-	Other /Soc	city)
Division of	anding Ph ath. or: After th	Certification; T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not by	28a. Date of (Month,	njury 28t Day Year)	. Time of Injury	M 28	Bc. Injury Work 1 \( \) Y		2	8d. Describe ho			City
Divi	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu		3 Suicide 4 Homicide  6 Could not be determined	building	Injury - At home, etc. (Specify)						City or Town	, State)		ural Route Number,
	To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Exam	niner: On the basi and manner	s of examination	and/or in	vestigation,	in my op	inion, deat	h occurre	d at the time, da	ate and p	lace, and due	to the cause(s)
	To Your	2	TYVY	M-D -			29c.	D -	_38	75	4	t O	signed (Mont - 2-5	h, Day, Year) - 2005 - 21221
	H		77(7) = 11 77 0	SASREM	1. 5	709	Print)	AS	TEI	en	BLVI	) . 	MD	-21221
D1.	Sta Regist	rar	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signature	K A	foods	Þ						
DΗ	IMH 17 Rev 1/2	001	9010 1	A Part	Ol	RIGIN								

			State of Maryland / Department of Health and Certificate of Death	Mental Hy		)5	35008
			1. Decedent's Name (First, Middle, Last)	2. Dete of D	eath		3. Time of Death
	Physic		GABRIELLE MARIE JOHNSON	Octobe	Dey 7	Year 005	1015 AM
	/Medi Examir		4a Fecility Name (If not institution, give streat end number)  4b. City, Town, or				
7	Lxaiiii		Sinai Hospital of Baltimore Baltim	OFE		N/	Δ
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hr.	s. 8. Date of B	irth		llece (State or Foreign
- 1	Director		218-73-1357 1 M 2 F N/A Yrs. Months Days Hours Mir	Oct. 6			
	A 100	·	Usuel Residence of Decedent	IUCL. C	,200	Mar	yland
	anylen ahow		10a. State 10b. County 10c. City, Town or Location		-	1	0d. Inside City Limits
	the Maryle 28a-f ahor	j	Maryland N/A Baltimore				1 ☐ Yes 2 ☐ No
	or 28a-f	Director	10e. Street end Number 10f. Zip Code		10g. Citizen of	What Cour	itry?
	h wit	<u>=</u>	1528 Waverly Way 21239			IJSA	
	ter daat tems 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispenic Origin? (	Specify Yes or N		ce - Americ	
altimore, Maryland 21215-0036	within 72 hours after death with the Marylend ene. than "natural", or tems 23a or 28a-f ahow he Medical Exeminer must be notified at	by Fu	Armed Forces? If Yes, specify Cuban, Mexican, Pue  1 ☑ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☑ No  If Yes, Give △  Year or Dates:	no Hican, etc.)	Specif	ck, White, by: Bla	
ŏ	2 hou				16b. Kind of B		
15	n 7	Completed	(Specify only highest grede completed) (Give kind of work done during most of wo	orking			,
12	iene iene the	E	Elementary/Secondary (0-12) College (1-4or 5+) N/A		,	N/A	
D	e filad el Hygi other	O	17. Father's Neme (First, Middle, Last)  18. Mother's Na	me (First, Middle	, Maiden Suman		
an	d 2 should be filar th and Mantel Hyg 7 is merked other traumetic event,	To Be	Anthony Elbert Johnson Dani	elle Kiv	ette Loi	าย	
2	Should M.	- 1	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or F				Code)
Z	trau		(Parents)				,
ą,	Heal Heal	ł	20a Method of Disposition 20b. Place of Disposition (Name of	altimore Date	20c. Location	Inc. Z	LZ39 wn, State
ᅙ	nt of nt of nt of		1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete				
臣	rtant rtant	-	4 Donation S Other (Specify) Green Mount Cemetery  21. Signature of Funeral Service Ligenses 22. Name and Address of Facility	10/28/2	005 Balt	.imore	e, Maryland
Ba	permit. Pages 1 end 2 Depertment of Health a Important: If Item 27 is any Injury or other tran		Mitchell-Windofol	d Funera	1 Home.	Inc.	
	40-40		Martin D. Lawson 6500 York Road, B.	altimore	Marvla	and 2	1212
			Martin D. Lawson 6500 York Road, B.  23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial shock, or heart failure. List only one cause on each line.	c or respiratory	arrest,		Approximate Interval Between
	Physician					i i	Onset and Death
7	/Medical		Immediate Cause (Final disease or condition Interference on In				3 hours
	Examiner		resulting in death)  Due to (or as a consequence of):				-
	p #	edical Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Intestinal perforation  Due to (or as a consequence of):  b. Necrotizing Enterocoliti  Due to (or es a consequence of):	5			15 hours
	ficate be executed physicien end is the buriel-transit	am	Sequentially list conditions,  Due to (or es a consequence of):				18 days
oʻ	e exe	0	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury				18 days
68760,	icate be execu physicien end s the buriel-tra	S	Cause (Disease of Injury C. Due to (or as a consequence of):				/-
39							
Вох	th ce endi	2	d				-
Э.	dee ne et ed fo	S	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did	tobacco use co	ntribute to	the cause of death?
P.O.	of the	Å.	Goods to the state of the state	1	Yes 2 No	3 Prob	ably 4 Unknown
Ś	and the grand de de	by	Dacterial sepsis				
P	aw requires thet tha deeth certif as bean signed by the ettending 2 should be detached for use e	8	Meningitis	24a. Was	an autopsy ormed?		ere autopsy findings ailable prior to
ပ္ထ	s be	plet	MENINGITIS	pon	ominou.	cor	npletion of cause deeth?
æ	ha law a has age 2	E		1[	Yes 2 No	15	]Yes 2□ No
ā	ifical	CO	25. Was case referred to medical 26. Place of De	eath (Check only	onel		
Division of Vital Records,	Attending Physician: The law requires thet the deeth certi or death.  sctor: After this cartificate has been signed by the ettending by the attending by the the the better this cartificate. The page 2 should be detached for use to the the time at the page 2 should be detached for use to the page 2 should be detached for use to the page 2 should be detached for use the page 3 should be detached for use 4 should be	0 8	examiner?		idence 6 □Oth	er (Specifi	d
ō	Phy ir this eral c	발	27. Menner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		how injury occur		//
o	th. Afte		1 Natural 5 ☐ Pending (Month, Dey Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No				
18	dea ctor y the	fice	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location	Street and Numb	er or Rura	l Route Number,
Š	after Dire	ert	4 ☐ Homicide building, etc. (Specify)	City or To	wn, State)		
	spita ours veral	0	29a. Certifier  12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place	e. and due to the	cause(s) end ma	anner es st	eted.
	To the Hospital or Attending Physician: Tha is within 24 hours after death.  To the Funeral Director: After this cartificate ha completaly filled in by the funeral director, page.	Medical Certification: To Be Completed by Physician/M	(Check only one) Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurrence on manner stated.	urred at the time	date and place,	and due to	the cause(s)
	vithin o th	Me	29b. Signature end title of certifier 29c. License number		29d. Date signe	d (Month, i	Day, Yeer)
	F > F 0		DO061593	,	october	23 2	2005
		-	30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)  David Kanter, M.D. Sinai Hospital 2401 W. BEIVE		-,	, -	-
,			30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)  David Kanter, M.D. Sinai Hospital 2401 W. Brive	16-1-1	V. 6.	11:2	1215
			David Kanter, M.D. Sinai Hospital 2401 W. BEIVE 31. Date filed (Month, Day, Year) 32 Registrer's Signature	eacre 4	VE. Da	mmc	119 1110
1	Sta Registr		OCT 3 1 2005				
\			The state of the s				

**ORIGINAL** 

			1 - State Registrar	State of Maryla		artment ertificate			F	Reg. No 2	105	35009
, and the second	Physici /Medio Examir	al	Decedent's Name (First, Middle, Last)     Anne Catherine Kno     4a. Facility Name (If not institution, give st			4b. City, To	own, or Lo	cation of Dea	2. Date of Dea	t Day 26	Year 2005 ity of Death	3. Time of Death
	Funeral Director	C1	Bel Air Health an 5. Social Security Number 6. Sex	dRehab (	rs. last birthday Yrs.	Bee	Ac Year If	Under 24 Hr Hours Mir	s. 8. Date of Birt	h v, Year)	9. Birth	place (State or Foreign ntry) yland
	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  Md. Harford	10c.	City, Town or L	ocation Aberd	een		Julie 0,	1717		10d. Inside City Limits 1 ☐ Yes 🏖 ☐ No
	3a or 28a	Funeral Director	10e. Street and Number 3135 James Run Roa	d		10f. Zip C	21001			10g. Citizen of		ntry?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heelih and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f ahow other traumatic event, the Medical Examinet must be notified at	ğ	11. Marital Status 1: 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	1 U.S. 13.	Was Decede If Yes, specif		anic Origin? ( Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		ace - Americ lack, White,	etc.
Maryland 21215-0036	d within 72 ho giene. Ir then "netur Ine Medicel.	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12) 8 years	ation completed) College (1-4or 5+)	(Giv	edent's Usual e kind of work DO NOT use sperson	done duri retired)	n ng most of w	orking	16b. Kind of		ndustry
yland	2 should be filed and Mental Hygie is marked other aumatic event,	To Be C	17. Father's Name <i>(First, Middle, Last)</i> August Leineweber						ame (First, Middle, n Hetchan		ıme)	
	1 and 2 sho Heelth and em 27 is mu		19a. Informant's Name/Relationship (Typ Elmira Hodges/daug	hter	3135	James	Run		Aberdeen	, Md.	21001	
Baltimore,	permit. Peges 1 Department of H Important: If ite any Inlury or oti		20a. Method of Disposition  1  Burial 2 □ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)	moval from State	ak Lawr	ematory or oth Cemet	erplace)	1	Date 29/05	Balti	more,	
Bal	Depar Impo		21. Signature of Funeral Service Licenses  23a. Part1. Enter the disease, or complic			610 W.	nek l Macl	Funera Phail	l Home of Road, Bel	Air.	ir, I	nc. 1014 Approximate
	Physician /Medical Examiner		shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.	moni		oi dying, s	uch as cardi	ac or respiratory ar	rest,		Interval Between Orlset and Death
8760, <	death certificate be executed e attending physicien and for use as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d. d.	Due to (or as a cons								
P.O. Box 68	that the death certifice ted by the attending phice detached for use as ti	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3	□Ectopic pred □ Other (spec				1	Date of deliver	ery Day Year
	The law requires that the tite bes been signed by the bage 2 should be detache	þ	Part II. Other significant conditions cont	ributing to death but not	resulting in the	underlying cau	use given i	n Part I.	23e. Did to	2	ntribute to ti	he cause of death?
of Vital Records,		e Completed	25. Was case reterred to medical						1 Yes	rmed? 20 No	prior to co death?	opsy findings available impletion of cause of
Division of Vi	Attending Physicien: r death. ector: After this certifica by the funeral director, I	ToB	examiner?  1 Yes 2 No  27. Magner of Death  1 Natural 5 Pending 2 Accident Investigation	2 spital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year	2 ER/Outpatie 28b. Time Injury	of 28	Other: c. Injury at Work?	4 Nursing	Home 5 Resident Resid	lence 6 🗆 O		(y)
Divis	in Title	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	ecify)				City or Tow	m, State)		al Route Number,
	To the Hospital within 24 hours a To the Funerel I completely filled	Medical	(Check only I Medical Examin	cian: To the best of my er: On the basis of exam and manner stated.	knowledge, dea nination and/or i	nvestigation, i	t the time, in my opini License no	on, death occ	curred at the time,	date and place	e, and due to	o the cause(s)
	7 3 2 8		29b. Signature and title of certifier	MD		_	T 2		t t	Octob,		7,2005 21014
45	H	ate	30. Name and address of person who core Scoth / ASwell  31. Date filed (Month, Day, Year)	2 Non 32. Registrar's Si	gnature (Type	INV (	Be	1 /	in Mo	iry/a	end	21014
	Regist		OCT 3 1 2	005	. 13.	goods!	r					

Anna C. Knott

State of Maryland / Department of Health and Mental Hygiene 350 I O Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Christopher King <u>10:05</u>a<sup>™</sup> 10 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Manor Care of Silver Spring Montgomery Silver Spring If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1√3M 2□ F Min. 58 Yrs. Director 578-86-4753 06-28-1947 North Carolina Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 27 is marked other than "natural", or Itams 23e or 28e-f show traumatic event, the Medical Exactly at mast be notified at 1 X Yes 2 ☐ No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 2501 Musgrove Rd. #127 USA death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If Itam 27 is marked othar than "natural", or Ita 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: White þ 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Unknown 0 Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willis King Frances Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen King/brother P.O. Box 510 Little Switzerland NC 28749 othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 0 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Chesapeake Crematory 10-26-2005 1 4 □ Donation 5 □ Other (Specify) Beltsville MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Service mo1358 933 Gist Ave Silver Spring MD 20910 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres shock, or heart failure. List only one cause on each line. Immediate Cause (Final Recurrent Aspiration Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Down's Syndrome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner executed use as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician certificate be Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) à Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð page 2 should be 1 Yes 2 No 3 Probably 4 Junknown Completed Dementia 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No To the Hospital or Attanding Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident 5 Pending investigation after death.

I Diractor: Aft
d in by the fur М 1 ☐ Yes 2 ☐ No n 24 hours after der he Funeral Diracto pletely filled in by th 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D50545 10-25-2005 1007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Godewill O. Okojie 7513 New Hampshire Ave Takoma Park MD 20912 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 18 36 Registrar 2005

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State of Maryland / Department of Health and Mental Hygieney Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2 2005 LUNN OLTOBER 6+ FNIMIE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northwest Hospital Center Randallstown
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Baltimore Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 □ F 74 Director 250-48-5557 12/12/1930 South Carolina Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits it of Heelth and Mental Hygiene.
If item 27 is marked other than "natural", or items 23s or 28s-f show or other treumstic event, it a Modical Examinar must be notified at Maryland 1 Yes 2 □ No Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 329 East 28th. Street 21218 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 TNo If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Day Care Provider Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Depertment of Heelth and Menta Importent: if item 27 is marked any injury or other treumatic evones. Prince Taylor မ Sirleaner Bryant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 329 East 28th. St., Baltimore, Maryland 21218 James Lunn / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) Loudon Park Cemetery 10/31/2005 Baltimore, Maryland 22. Name and Address of FacilityThe Derrick C. Jones F/H, P.A. 21. Sanature of Funeral Service Lice 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MEUMONIA /Medical Due to (or as a consequence of): Examiner SEVERE RESPIRATOR ACIDOSIS Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed use as the burial-transit MUDITANIFMENOUPM OBESITY been signed by the attending physicien and should be deteched for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 D(No 9 ☐ Unknown 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nonknown MELLITUS DIARETES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? this certificate 1 ☐ Yes 2 X No 1 Yes 2 No or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification; To 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicar Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie. 29c. License number octoha 26h, om allo 041410 JOGINDER P MEHTA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MORTH WEST HUSPITM CENTER RAMORUSTOWN 21133 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar OCT 3 1 2005

DHMH 17 Rev 1/2001

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		1	For Stata Ragistrar	State of M		id / Dep	artment o	of Health	and M	ental Hyg		105	350	12
Phy	sician	1.	Decedent's Name (First, Middle, Last) Michael Scott Lac							2. Date of Dea Month	Day	Year	3. Time of 6:35	Death
	edical iminer	48	Facility Name (If not institution, give s	street and number)		are		on, or Location		October	4c. Coi	unty of Death	0.75	
Fune Direc			Social Security Number 6. Sex	7. Ag		last birthday Yrs.		ear If Under ays Hours	Min	8. Date of Birth (Month, Day June 1,	, Year) 1980	9. Birth	olace (State o ntry) yland	r Foreign
Maryland a-f show	ctor	1	Md. Harford	1	10c. Cit	y, Town or L		Air					0d. Inside Ci	
with the	i Dire	10	De. Street and Number 2108 Woodtop Way				10f. Zip Co	de 21015			-	of What Cou	ntry?	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: If item 21 is marked other than "natural", or Items 23a or 28s-1 show any intervor in the tranmatic event.	by Funeral Director	1		12. Was Decedent Armed Forces 1 Yes 21 If Yes, Give Year or Dates:	?	.S. 13.				cify Yes or No- Rican, etc.)	14.	Race - Ameri Black, White,		
21215-0036 od within 72 hours atl giene. er than "natural", or	Completed	-	15. Decedent's Educ (Specify only highest grade	cation completed) College (1-4or	5+)	16a. Dece (Give life.	edent's Usual O e kind of work o DO NOT use r	ccupation one during mos stired)	st of workin	ng	16b. Kind o	of Business/In	dustry	
Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importants it lieue 27 is marked other than 'n	Be Con	1	7. Father's Name (First, Middle, Last)  Denver Lee Lacey	2 Ir			st			(First, Middle,	Maiden Sur	ollege		
Maryland od 2 should be file lih and Mental Hy 27 is marked oth	To		9a. Informant's Name/Relationship (Type Scott E. Brown/st	pe, Print)	<u> </u>			reet and Numb	er or Rural	Route Numbe	r, City or To		Code)	
Baltimore, bermit. Pages 1 ar Department of Hea mportant: If item:	o do come	2	Da. Method of Disposition  1 Burial 2 Cremation 3 R  4 Donation 5 Other (Specify)	emoval from State			osition (Name of amatory or other			7/2005		on - City or To		
Baltii Poermit Poepartm	ony injur	2	Signature of Funeral Service License	H	30		Name and A Schimur	ddress of Facili	eral 1	Home of	Bel.	Air, I	nc.	
Physici /Medic	cal	1	3a. Part1. Enter the disease, or complishock, or heart failure. List only or mediate Cause (Final isease or condition asulting in death)	e cause on each l	ine.			dying, such as		ad, 8e1 r respiratory arr		Mu. Z	Approximate Interval Betwoenset and E	ween Death
68760, criticate be executed minimum in gphysician and mas the burial-transit	e e		equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury nat initiated events ssutting in death) Last	Due to (or as										
Box 6 ath certif	ian/Me	11 2	FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant a	2 Feta	I death 3	□Ectopic pregr □ Other (specif				23d.	Date of delive Month		/ear
rds, P.O. I juites that the den signed by the a	2	,	art II. Other significant conditions con	stributing to death t	out not res	ulting in the	underlying caus	e given in Part	l.			contribute to the	,	
Vital Records, sician: The law requires to certificate has been signed reacher loade 2 should have	v Ω	-								24a. Was a autop: perfor	SV	Ib. Were auto prior to co death? 1  Yes	psy findings a mpletion of ca 2 No	available ause of
on of	tion: T		5. Was case referred to medical examiner?  1	ospital: 1 XInpati 28a. Date of Inju (Month, Da		ER/Outpatie 28b. Time Injury	ont 3 DOA of 28c.	Othon	ursing Hom 2	(Check only or ne 5 Residant R	ence 6 🗆		γ)	
Division tall or Attending safter death.	Certification:		3 Suicide 6 Could not be determined	28e. Place of In building, e	jury - At h tc. <i>(Specil</i>	ome, farm, s	treet, factory, of	fice	2	8f. Location (S City or Town		ımber or Rura	l Route Numi	ber,
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After Agency According to the funeral in by the funeral properties of the funeral	Medical	2	9a. Certifier 1	sician: To the best ner: On the basis of and manner st	of examina	owledge, dea ition and/or i	nvestigation, in	my opinion, dea	nd place, ath occurre	d at the time, d	late and pla	ce, and due to	the cause(s)	)
ToT	2	2	9b. Signature and title of certifier	1017/2_				cense number	C			gned (Month,		
6	)	3	O. Name and address of person who co		death (Item			Baltin	nore	2401 W	Believe	re Ave,	Baltimar	MD
Reg	State gistrar	3	1. Date filed (Month, Day, Year)  OCT 3 1 2	32. Regist	rar's Signa	ature	marie						212	.15

Patient known as Michael Lacey

		1	For State Registrar	State of Marylar	-	artment of I			giene Beg:No.0 0 5	35013
	Physicia /Medic	an al	1. Decedent's Name (First, Middle, L Mary Dolores	Linsenmeyer				2. Date of De Month	Day Year 24 2005	3. Time of Death  11:59 pm
	Examin Funeral			Care Center Sex 7. Age (In yrs	. last birthday)	4b. City, Town, or Baltim If Under 1 Year Months Days	ore,	MD		TE thplace (State or Foreign buntry)
	Director Month		Usual Residence of Decedent 10a. State 10b. County		Yrs. ity, Town or Lo			March 2	20, 1911 M	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the Ma 3e or 28a-f s	Funeral Director	MD Baltim  10e. Street and Number  6401 N. Charl		(I C IIIO	10f. Zip Code 2121	2		10g. Citizen of What Co	
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Menth Hygiene.  If item 27 is marked other then "natural", or items 23e or 28e-f show or other traumatic event, the Madical Exama per must be notified at	by Funera	11. Marital Status  Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in 1 Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☐ No		igin? (Specify Yes or No n, Puerto Rican, etc.)	14. Race - Ame Black, White Specify: W	te, etc.
21215-0036	within 72 hou ene. then "natura he Wedical E	Completed	15. Decedent's (Specify only highest g	College (1-4or 5+)	(Give	dent's Usual Occu e kind of work done DO NOT use retire	pation during mos ad)	t of working	16b. Kind of Business	Industry
	should be filed a ind Mental Hygie marked other i umatic event, II	To Be Co	17. Father's Name (First, Middle, Las John Linsenme	yer			Mai	er's Name (First, Middle	, Maiden Surname)	
Mar	1 and 2 sho Health and em 27 is ma ther trauma		19a. Informant's Name/Relationship Bernice Feili 20a. Method of Disposition	nger, SSND	640 Place of Disp	1 N. Ch	arles		to. MD 212	212
Baltimore,	rtmer rtent njury	į	1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	oity)   V 1	.lla M	2. Name and Addr	ess of Facili	•	Glen Arm	,
ă	permi Depa Impo any ii		23a. Part1. Enter the disease, or co shock, or heart failure. List on	molications that caused the dead one ceuse on each line.	ath. Do not en	ter the mode of dy	ing, such as	cardiac or respiratory a		Approximate 12 Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse	equence of):	THRE	480	515		7.045
8760,	that the death certificate be executed ed by the attending physician and detached for use as the buriat-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Entar underlying Cause (Disease or injury that initiated events resulting in death) Last	c						
O. Box 68	he death certifica r the attending ph ched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2□ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	□Ectopic pregnan	су		23d. Date of de Month	olivery Day Year
ords, P.O.	v requires that the been signed by th should be detache	5	Part II. Other significant conditions	s contributing to death but not re	esulting in the	underlying cause g	iven in Part		tobacco use contribute t	o the cause of death?
Vital Records,	The law ate has b page 2 st	Completed	25. Was case referred to medical				26 Plac	perf	prior to death?  2 No 1 Ye	utopsy findings available completion of cause of s 2 No
>	Physiclen: this certific ral director,	To Be	examiner?  1 Yes 2 No	Hospital: 1   Inpatient 2	☐ ER/Outpatie	ent 3 DOA	Ab. a		idence 6 Other (Spe	ecify)
Division of	fing After fune	Certification: 7	27. Manner of Death  X☑Natural 5 ☐ Pending 2 ☐ Accident investigal 3 ☐ Suicide 6 ☐ Could no			M 1[	]Yes 2□	]No	how injury occurred	
Divis	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director; After completely filled in by the funer	Certifle	4  Homicide determin					City or To	(Street and Number or Fown, State)	
	the Hos thin 24 ho the Fun impletely i	Medical	(Check only one)  29b. Signature and title of certifier	aminer: On the basis of exami	nation and/or i	nvestigation, in my	opinion, de	ath occurred at the time	, date and place, and du 29d. Date signed (Mon	e to the cause(s)
	Z 2 Z 8		30. Name and address of person wi	o completed cause of death (It	em 23a) (Type		00 /3	373	OCTOBE	125 2005
		ate	Francis Carmo 31. Date filed (Month, Day, Year)	dy MD 7505 32 egistrar's Sig	Osler	Drive,	Tows	son, MD 2	1204	
	Regist	rar	001012	OUJ Select .	A. A.	as as				

**AEM** Amend/Unpend item#4a, 23c, 23d, 23d, 25d, pellible in 85 First 17 All Sopies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 05-07268 Cokeya Owens 1 - For Stete Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician OWENS OKEYA 2005 October 0 28. 4:46 A /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City
Under 1 Year | If Under 24 Hrs. <del>Uiversity</del> Hospital n/a 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 M 2 KF Months Days Hours 216-04-480 Yrs Director JULL Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. fnside City Limits 10a. State 10b. County or 28e-f show other traumatic event, the Medical Examinar must be notified at 1.XYes 2 □ No Director MARILAND 10e. Street and Number Citizen of What Country? 3 9 USA. 14. Race - American Indian, or items 23a SUCH AVENUE Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Year or Dates: 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) Coflege (1-4or 5+) 12 + "GRADE LIANCE INCORPORATED STUDEN7 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be . Pages 1 end 2 should be fill thent of Heelth and Mental H tant: If item 27 is marked ot UBB GRIFF 2 19b. Mailing Address (Street and Number or Rural Route/Number, City or Town, State, Zip Code) 19a. Informant's Name/Rela Inship (Type, Print) 39 GORSUCH AVE. ROSALYN 2121 Place of Disposition (Name of cemetery, crematory or other place) 20b. Date/ 20a. Method of Disposition 20c. Location - City or Town, State ₽ Burial 2 ☐ Cremation 3 ☐ Removal from State ō Department of important: If eny injury or once. CEMETERY 11-03-05 4 □ Donation 5 □ Other (Specify) LANSDOWNE 2. Name and Address of Facility BROWN 2140 N. FULTON AVE 21. Signal to of Funeral Service Licensee JR, FUNERAL HOME BALTO, MD. 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Finaf **Physician** Diffuse alveolar damage with acute pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of the burial-transit Due to (or as a consequence of) Box 68760 The law requires that the death certificate be Be Completed by Physician/Medical as use IF FEMALE: ff yes, outcome of pregnancy 1XLive birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 2 Yes 2 □ No for Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death P.O. 9 Unknown 10 16 05 signed I Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were aulopsy findings available prior to completion of cause of death?

1 2 Yes 2 □ No 24a. Was an Yes certificete 2 □ No Division of Vital Hospital or Attending Physicien: director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 examiner? Other: ٩ 1X∑Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) his After this funeral d 27. Manner of Death 1 Natural 28b. Time of 28c. 28d. Describe how injury occurred Certification: Injury all Work? Injury 5 Pending in Pospins, after death.
In 24 hours after death.
the Funerel Director; After the funerel of the 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 To the the e 29c. License number OCME 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) October 29, 2005 Baltimore, Maryland 21201 Seled cause of death (Item 23a) (Type, Print) 111 Penn Street 30. Name and addre 32. Registrar's Signature 2 31. Date filed (Month, Day, Year) State 3 Registrar 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 530 A **Physician** 25 2005 Peters chobe Me /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bultonor Genesis Perrine Mme PENLUICE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. Hours Maryland 90 Months Days 1 □X M 2 □ F 216-12-9552 July 14, 1915 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28e-f show item 27 is marked other then "natural", or Items 23e or 28e-f show other treumetic event, the Mail a Experiment must be treitled at 1 ☐ Yes 2 ☑ No Baltimore Baltimore Maryland Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21236 U.S.A. 8205 Berryfield Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural, or Item any injury or other treumetic event, If w Mical Exeminations. 1 XYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Baltimore, Maryland 21215-0036 Specify: þ ww II 3 XWidowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Electrician 9th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hebler Peters Theresa Joseph 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8205 Berryfield Drive, Baltimore, MD Mrs. Mary Karczeski (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Baltimore Nat'l Cem. 10/28/2005 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Carelierngopout Priysician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death use 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year ō in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 🗆 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 Yes 2 No 3 Probably 4 Worknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed 1 Yes 1 Yes Division of Vital To the Hospitel or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient Other: 4 Sersing Home 1 Yes 2 No 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 10 this After thi funeral of . Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funerel Director; in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of geath (Item 23a) (Type, Print)

Registrar

Peruse. 31. Date filed (Month, Day, Year) OCT 3 1 2005

Good Sphuaritan Hospital 2. Registrar's Signature

Feltende

Please Type or Print in Black Indelible Ink.	<b>Ensure All Copies Are Legible</b>
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			1 - For State Registrar	State of Mar		rtment of Heal tificate of Dea			2005	35016
1	Physici	an	1. Decedent's Name (First, Middle, Last)  Margaret M.	Sahafar				Date of Death Month	Day Year 28 2005	3. Time of Death
	/Medic Examir		4a. Fecility Name (If not institution, give s	treet and number)		4b. City, Town, or Loca	ation of Death	ctober	4c. County of Deat	
*		Q.	Sinai Hospital  5. Social Security Number  6. Sep	of Baltin	(In yrs. last birthday)	Baltimore If Under 1 Year   If U		Date of Birth	Q Rint	hplace (State or Foreign
	Funeral Director		187-14-7559 Usual Residence of Decedent	M XXF	81 Yrs.		ours Min.	Date of Birth (Month, Day, Y	1924 Pe	nnsylvania
	how		10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	28a-1	ecto	MD Baltim  10e. Street and Number	ore	Randal	1stown		100	. Citizen of What Co	1 Tes XXNo
	h with 3a or	ai Dir	3600 Anne Hatha	way Dr.	Apt.1D	21133	,	109	U.S.A	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene important: If item 27 is marked other than "naturel", or items 23s or 28s-f show with injury or other traumatic event, tre Medical Exempler rusal be multiplual at ance.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  XX Widowed 4 □ Divorced	12. Was Decedent Ev Amed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates:		Vas Decedent of Hispan Yes, specify Cuban, Me	nic Origin? (Specifi exican, Puerto Ric pecify:	y Yes or No- an, etc.)	14. Race - Ame Black, White Specify: W	
21215-0036	72 hou	Completed	15. Decedent's Edu (Specify only highest grade		(Give	ent's Usual Occupation kind of work done during	g most of working	16	6b. Kind of Business/	Industry
121	within ane. than "	iduu	Elementary/Secondary (0-12)	College (1-4or 5+)	) life. L	00 NOT use retired) Homemaker			Own Hor	10
	other	Be Co	17. Father's Name (First, Middle, Last)				Mother's Name (F	irst, Middle, Ma		iie
ylar	Menta Menta arked atic ev	To E	John Henry St				Mildre			
Maryland	d 2 sh th and 7 ie m traum		19a. Informant's Name/Relationship (Ty Gail Schafer/S			g Address <i>(Street and N</i> Ocean Parl		_	City or Town, State, 2  MD 218]	
	s 1 an if Heal item 2 other		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	Date		c. Location - City or	
Baltimore,	Page ment o ant: If ury or		XXBurial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)		Memoria1		11/3/	′05 <u> </u>	Finksbur	g, MD
Balt	Depertition Depert		21. Signature of Furieral Service License	19/			Facility Eckh	ardt F	uneral C	hapel P.A.
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the						.1s,MD21117 Approximate
	Physician		shock, or heart failure. List only or Immediate Cause (Final disease or condition	A Cuta	Myocas	rdial In	farelin	^		Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	3/1	Tareno			e varys
		ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):					
V	and I-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):					
8760,	cate be executed physician and the burial-transit	dical E		1	551754 <b>55</b> 175					720-714
9			IF FEMALE:							
P.O. Box	ires that the death certif signed by the ettending d be detached for use a:	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No 9  Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at til 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	very Day Year
	s that the ned by detact	by Ph	Part II. Other significant conditions con	tributing to death but	not resulting in the ur	derlying cause given in	Part I.	23e. Did toba	cco use contribute to	the cause of death?
rds	w requires been sign should be							1 ☐ Yes	2 No 3 Pr	obably 4 Unknown
Il Records,	The la ate has page 2	Completed						24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of
Vital	Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital:	2 ER/Outpatien		Place of Death C		ce 6 □Other (Spe	2.50
Division of	nding Physician: th. The this certific funeral director.	ation: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b. Time of	28c. Injury at Work?  M t Yes	280		injury occurred	лу)
Divis	To the Hospital or Attending Pr within 24 hours after death. To the Funerel Director: After it completaly filled in by the funera	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home, farm, str (Specify)	eet, factory, office	28f.	Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,
	e Hospit 124 hour Funer fetaly fills	edical (	29a. Certifier 1 Certifying Physical Control (Check only one) 2 Medical Exami	sician: To the best of ner: On the basis of e and manner state	examination and/or inv	occurred at the time, de restigation, in my opinion	ate and place, and n, death occurred	I due to the cau at the time, date	rse(s) and manner as a and place, and due	stated. to the cause(s)
<b>•</b>	To the within	M	29b. Signature and title of certifier  Kazi A. Za	man, M.	D.	29c. License nun RES	nber - 000		1. Date signed (Monti	9, 2005
	4		30. Name and address of person who co	4 4 A	ath (Item 23a) (Type, SINA	HOSPITI	AL OF	BALTIE	MORE	
	St: Regist		31. Date filed (Month, Day, Year)	32. Registrar						
DH	MH 17 Rev 1/2		OCT 3 1 20	05 Seren	J. J.	ale				
					ORIGIN	IAL				

Registrar

31. Date filed (Month, Day, Year) 3 1 2005

29b. Signature and title of certifier

32 Registrar's Signature

Nhers

30. Name and address of person completed cause o death (Item 23a) (Type, Print) 111 Penn Street

M.D

goste

29c. License numbe

OCME

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21201

October 27, 2005

State of Maryland / Department of Health and Mental Hygiene 35018 1 - For State Registra Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death THOMAS 28, 2005 4c. County of Death **Physician** UCTOBER 1.50,4 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 301 11 MORE If Under 1 Year | If Under 24 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2□ F 215-30-8 Director 89 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits item 27 is marked other then "naturel", or items 23s or 28e-f show other treumstic event, the Medical Experiment must be notified at 1 X Yes 2 □ No Funeral Director MARYLAND 10e. Street and Number Og. Citizen of What Country? 20 RANKLIN death permit. Pages 1 and 2 should be filed within 72 hours after dean Department of Health and Mental Hygiene. Importent: If ten 27 is marked other theory any injury or other treum—" 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TEACHER BALTO CITYPUBLIC T MASTERS DEGREE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 19a. Informa s Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 THET FORD ROAD 20c. Location City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 10-31 \* 4 ☐ Donation 5 ☐ Other (Specify) CREMATORY 21. Signature of Funeral Service License JR. FUNERAL HOME BROWN 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-transit P.O. Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performe 2 🗆 No 2 No 1 Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 patient P 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours and To the Funerel Dir f Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D003035 who completed cause of death (Item and address of p 23a) (Type, Print) BON SECOURS (0911 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 1 Registra

			Trogional .	partment of Health and Nertificate of Death	Reg. No. 000 33019
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year  Year
	/Medic	al	Helen S. Troyer  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	October 30, 2005 2:30A M
	Examin	er	14912 Dover Rd.	Reisterstown	,
	Funeral		5. Social Security Number 6. Sex 7. Age (In vrs. last birthday	) If Under 1 Year If Under 24 Hrs.	
	Director		212-20-0558 1 M XX 79 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 26,1925  8. Birthpiace (State or Foreign Country) Maryland
	and *		Usual Residence of Decedent           10a, State         10b, County         10c, City, Town or I	ocation	10d. Inside City Limits
	Maryli f aho	o		erstown	1 ☐ Yes <b>②CX</b> No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	th with	al D	14912 Dover Rd.	21136	U.S.A.
	r dea	Juer	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecfly Yes or No- Rican, etc.)  14. Race - American findian, Black, White, etc.
36	within 72 hours after death with the Maryland ene. Than "natural", or Itams 23e or 28e-f show ha Medical Examinar neust be nicitied at	Completed by Funeral	1 □ Never Married XXMarried 1 □ Yes X2 X No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes XXNo Specify:	Specify: White
Ş	2 hou atura cal E	ted t	15. Decedent's Education 16a. Dec	edent's Usual Occupation	16b. Kind of Business/Industry
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21	filed wii Hygien other th	Con	12	Homemaker	Own Home
and	ntal H od otl	Be	17. Father's Name (First, Middle, Last)  Robert Smith		ma Nail
Maryland 21215-0036	should nd Me mark matic	ပ္			al Route Number, City or Town, State, Zip Code)
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ore,	es 1 a of He fitam rothe		20a. Method of Disposition 20b. Place of Disposition	position (Name of ematory or other place)	Date 20c. Location - City or Town, State
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If time 27 is marked other than "natural; or Itams 23a or 28a-f show any injury or other traumatic avant, in a Medical Examinar must be ricilited at once.				chardt Funeral Chapel P.A. wn Rd.; Owings Mills, MD2111
			23a. Part1. Enter the disease, or complications that caused the death. Do not e		
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	Can Alexa	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence of)	Carrenae	acuu
ı	Examiner		Successfully list conditions. b. by pentil	insoon	
7	sit ad	Iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
V	be executed sicien and burial-transit	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):		
,097	ires that the death certificate be exigned by the ettending physicien does detached for use as the buria	calE	d-		
89	tificat ng phy as th		J. C.		
Вох	The law requires that the death certifica ate has been signed by the ettending phage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy   1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy	23d. Date of delivery  Month Day Year
0.	ne dea the et hed fo	/sici	in the past 12 months?  1	Other (specify)	Month Day Year
<b>a</b>	that the ed by detact	Ph/	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I,	23e. Did tobacco use contribute to the cause of death?
Records,	quires n sign ald be	d by			1 Yes 2 No 3 Probably 4 Unknown
ဝွ	aw requir s been si 2 should I	plete			24a. Was an 24b. Were autopsy findings available
Ĕ.	The I	Completed			autopsy prior to completion of cause of performed? death?  1 Yes 2 No 1 Yes 2 No
Vital	sician: The law certificate has t irector. page 2 s	Be (	25. Wat case referred to medical examiner?		h (Check only one)
0	Phy this	10	1		me 5 Residence 6 □Other (Specify)  28d. Describe how injury occurred
Division of	ding h. After funer	tlon	27. Manner of Death  1 Avatural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time Injury	Work?  M 1 □ Yes 2 □ No	28d. Describe flow injury occurred
S	Atten	Ifica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s	street, factory, office	28f. Location (Street and Number or Rural Route Number,
	rs afte	Certification:	4 Homicide Soleminios building, etc. (Specify)		City or Town. State)
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)
	To the within 2 To the complet	Med	one) and manner stated.  29b. Signature and title of certifie.	29c. License number	29d. Date signed (Month, Qay, Year)
	£ ≥ ₹ 8		Dan lettym	157705	10/31/05
	~		30. Name and address of person who completed cause of death (Item 23a) (Type	a, Print) SILG RA	TIMORE COM
	8		AGRAHAM MATHEW, MO	7 FINARION	TIMORD YLVD
i.	Sta		31. Date filed (Month, Day, Year) 32. Register's Signature	Andrew	0.00
	Registi	reli	OCT 3 1 2005	aparer .	

			For	State of Marylan		artment of Herificate of L				35020
			Registrar  1. Decedent's Name (First, Middle, La	et)	Ce	runcate of L	Jeani	2. Date of De	Reg. No.	3. Time of Death
	Physici		Casnie T	hacata	t/\			Month	Day Year 7 25 2005	525 PM
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)	V 1	4b. City, Town, or	Location of Deat		4c. County of Dea	
	LAdiiiii	iei	North West Hos	pital Cent	e V	Kandal	Stow			more
	Funeral		5. Social Security Number 6. S	C C .	last birthday) Yrs.	Months Days	If Under 24 Hrs Hours Min.	(Month, Da	th y, Year) 9. Bir Co	thplace (State or Foreign ountry)
	Director		Usual Residence of Decedent	M 200 F 103				120	4 - 1901	VA
	yland how		10a. State 10b. County	1	ty, Town or Lo					10d. Inside City Limits
	Ba-1 s	cto		la Ba	LTIMOR				10 000 1000	1 XYes 2 No
	with the	Dire	3920 BAREVA R	DAD		10f. Zip Code 2121	5		10g. Citizen of What C	ountry ?
	na 23	Funeral Director	3920 BAREVA R	12. Was Decedent Ever in U	.S. 13.	Was Decedent of His	spanic Origin? (S	Specify Yes or No	- 14. Race - Am	
9	or Iter	Fur	1 ➡ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🕰 No If Yes, Give		If Yes, specify Cubar  1 ☐ Yes 2   No	n, Mexican, Puer Specify:	to Hican, etc.)	Black, Whi	
003	within 72 hours after death with the Maryland ene. than "natural", or Itema 23a or 28a-f show the Marical Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:					DL.	ACK
15-	in 72	ojete	15. Decedent's E (Specify only highest gra	ide completed)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	furing most of wo )	rking	16b. Kind of Business	
21215-0036	d withing giene.	Completed	1 1H GRADE	College (1-4or 5+)	SE	EAMSTRES	3		TAILORING	
	be filed htal Hygid ed other event, II	Be	17. Father's Name (First, Middle, Last						Maiden Sumame)	
Maryland	s 1 and 2 should be filed withir f Health and Mental Hygiene. Item 27 is marked other than other traumatic event, it w M	To	EMMANUEL THORN  19a, Informant's Name/Relationship (		19h Maili		GEORGI		THORNTON  or, City or Town, State,	Zip Code)
Ma	and 2 s saith an n 27 is i		OWEN THORNTON	(BROTHER)	3920			10. MO	0	,
Je,	of Health		20a. Method of Disposition	20b. F	Place of Dispo	osition (Name of matory or other place	)	Date	20c. Location - City or	Town, State
Baltimore,	Pag nent ant: I		1 Bunal 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Special	y) SH1		IPT. CHURC		9.05	REEDVILLE	, VA
Balt	permit. Pag Department Important: I any Injury o		21. Signature of Funanal Service Licer	nsio	V	2. Name and Addres	s of Facility	ERAL SER	VICE 21000	
		_	23a. Part1. Errier the disease, or com	plications that caused the deat		51 BAUD.NA ter the mode of dying				Approximate Interval Between
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	ASD1 V 6	a + 17	n Phy	Pum	onla		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq			. 1	01	1	
	Examiner	7.	Sequentially list conditions,	b. Upper (	QS-	roint	esti	natb	peed.	Days.
$\mathcal{J}$	uted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	- 1 - 1	,					
o,	be executed ician and burial-transit	Exa	resulting in death) Last	Due to (or as a conseq	uence of):					
8760,	ys of	dicai	•	d						
9	leath certifica attending ph I for use as th	/Med	IF FEMALE:	23c. If yes, outcome of pregna	ancv				23d. Date of de	livery
Вох	atten for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No	1□Live birth 2□Feta 4□Pregnant at time of d	al death 3	□Ectopic pregnancy □ Other (specify)			Month	Day Year
P.O.	that the de ed by the detached	hys	9 Unknown	9□ Unknown						
	ires tha signed d be det		Part II. Dther significant conditions	contributing to death but not res	sulting in the u	inderlying cause give	n in Part I.	23e. Did t	obacco use contribute t Yes 2⊠No 3□P	o the cause of death?
Orc	w requir been si should	eted						24a. Was		utopsy findings available
of Vital Records,	he faw e has i ge 2 s	Completed by					, ,	autor perfo	osy prior to death?	completion of cause of
tal		O)	25. Was case referred to medical				26. Place of De	1 ☐ Yes ath (Check only of	2 No 1 Yes	s 2)X No
<u></u>	Physician: this certific ral director,	ToB	examiner? 1 ☐ Yes 2 No		ER/Outpatie		4 🔲 Nursing i	Home 5 Resi		sub acure
	ding Ph I. After th funeral	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work	at :? /es 2 ☐ No	28d. Describe	how injury occurred	
Division	I or Attending after death. Director: After I in by the fune	ficat	2 Accident investigatio 3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Place of Injury - At h	ome, farm, st				Street and Number or R	ural Route Number,
<u>S</u>	s after al Dire	Certification:	4  Homicide	building, etc. (Specia	fy)			City or To	wn, State)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	nysician: To the best of my kno niner: On the basis of examina	owledge, deat ation and/or in	th occurred at the time	e, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	othe ithin 2 othe omplet	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number		29d. Date signed (Mon	th, Day, Year)
	⊢ 3 ⊢ ŏ		MILLAMO	Kojuli		620	912		October a	15 2005
•			30. Name and address of person who	dompleted cause of death (Iter	п 23а) (Туре,		1	0 1	0 1 11	1 -
			Christine Ka	JUBI NWHO	540	1010 (	DUYT	Koad K	Kandalls	town
	Sta Registi		31. Date filed (Month, Day, Year)	32. degistrar's Signa	B A	and I				

		-	- For	artment of Health and Mental I	Hygiene 8005 35021
	Physicia		1. Decedent's Name (First, Middle, Last)  TERRY  WEBB	2. Date of Menth	f Death 3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  BON SE COURS HOOFTA	4b. City, Town, or Location of Death  BALT, MERE	4c. County of Death
	Funeral Director		5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  233.98.7643	Months Davs Hours Min. (Month	f Birth   9. Birthplace (State or Foreign Country)  8   96   MD
	aryland show	_	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Li		10d. Inside City Limits 11€ Yes 2 □ No
	h the Marrians or 28a-f	Director	MD NA BALTIMORE	10f. Zip Code	10g. Citizen of What Country?
	leath wii	Funeral D	209 S. BENTLOU STREET  11. Marital Status  12. Was Decedent Ever in U.S. 13.	21223 Was Decedent of Hispanic Origin? (Specify Yes o	r No- 14. Race - American Indian,
39	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Evant at must be notified at	Ď	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Rican, etc.  1 ☐ Yes 2 No Specify:	Black, White, etc.  Specify: WHITE
21215-0036	in 72 hor n "naturi	Completed	(Specify only highest grade completed) (Give	adent's Usual Occupation a kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
	filed with Hygiene. other thai		Elementary/Secondary (0-12)  10 1H GRADE  17. Father's Name (First, Middle, Last)	ABORER  18. Mother's Name (First, Min	GAS PLANT
Maryland	should be f nd Mental h marked of	To Be	BILLY WEBB, SR.	LEONA KEND	DALL
Mar	and 2 sho ealth and n 27 is m			ing Address (Street and Number or Rural Route No. AROIN PARK ROW # 127	
iore,	ges 1 and 3 of Health I fiem 27 or other tra		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposemetery, creation	osition (Name of Date amatory or other place)	20c. Location - City or Town, State
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or of once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	DUNT   11.01.05   22. Name and Address of Facility AUGHN C. GREENE FUNER	BALTIMORE MO
	Proposition		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heat-failure. List only one cause on each line.  Immediate Cause (Final disease or condition	151 BALTO NATU PIKE BAL	10. MD 21229
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	Encephalopat.	hy
٦,	vate be executed by sician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	· Millitus	)
68760,	tificate be ng physicia as the bu	edical	d		
.O. Box (	ath cer attendir for use	by Physician/Me		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
s, P	that ed b	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	and onlying dates great are are	Did tobacco use contribute to the cause of death?
Vital Record	The taw requires ate has been sign page 2 should be	Completed		24a.	Was an 24b. Were autopsy findings available autopsy performed? death?
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death (Check of	
of	Phys this ral dir	ation; To	1   Yes 2   No   Nospitati. 1   Inpatient 2   ER/Outpatie  27. Manner of Death 1   Natural 5   Pending   (Month, Day Year)   Injury  2   Accident   Accide	of 28c. Injury at 28d. Desc	Residence 6 Other (Specify)
Division	Hospital or Attending 4 hours after death. Funeral Director: After tely filled in by the fune	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		ion (Street and Number or Rural Route Number, or Town, State)
	To the Hospital or Atterwithin 24 hours after de To the Funeral Directo completely filled in by the	ledical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal continuous continuo		
•	To the within To the comp	Me	29b. Signature and title of certifier R. Cruz M	△ D0030355	29d. Date signed (Month, Day, Year) October 25, 2005
	1		30. Name) and address of person who completed cause of death (11 23a) (Type RUSITA R. CRUZ M.	BON SECO	
	St Regist	ate rar	31. Ďate filed (Month, Day, Year)  32. Registrar's Signature	Carle	

Physici	ian	1- For Unpend Item 23a&27 per me C849 11-30-05 Las Certificate of Death  1. Decedent's Name (First, Middle, Last)	2	2. Date of Death Month October		2005	3. Time of D	eath
/Medi	cal	Heather Ann Worrall  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location		CLOBEL	4c. County		17.41	
Examir	ier	6225 York Road Baltimore				N/A		
Funeral Director		146-54-0901 1 M 2XX 42 Yrs. Months Days Hours	Min. J	Date of Birth Month Day UNE 7,1	963	9. Birthp Court Geor	lace (State or F etry). GIA	-oreig
iand ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location				1	0d. Inside City	
ith the Marylar or 28a-f show	ctor	Maryland N/A Baltimore					XX Yes 2	! 🗆 N
with the	Dire	10e. Street and Number 10f. Zip Code 225 York Road 21212		10	g. Citizen of US		itry?	
should be filed within 72 hours after death with the Maryland nd Mental Hygiene. Inarked other than "natural", or iteme 23e or 28e-f show unatic event, the Medical Exeminer must be notified at	Funeral Directo	11 Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic O	rigin? (Spec	ify Yes or No-	14. Ra	ce - Americ		
or iter	Fur	1 ☐ Yes 2√1 No 1 ☐ Yes 1 No Specify		ican, etc.)	Specif	ck, White,	<sub>etc.</sub> hite	
hours tural',	ed by	3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation			16b. Kind of B			
Medic Medic	Completed	(Specify only highest grade completed)  (Give kind of work done during mo life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)	ost of working	7	OD. INIIG OF E			
ygiene t, be	Com	1 Unemployed				N/A		
rked off tic even	To Be			First, Middle, N lizabet				
Department of Health and Mental Hygiene. Interpreted to theme 23a or 28a-1 ehov minortant; if item 27 is marked other than "natural; or iteme 23a or 28a-1 ehov any injury or other traumatic event; the Medical Examinar must be notified at once.		19a. Informant's Name/Relationship (Type, Print) Suzanne Elizabeth Worrall Mother 305 Meiers Lane	calif	Route Number, On New	City or Town Jersey	, State, Zip 0783	Code)	
nent of Healint: if item 2		20a. Method of Disposition  1 Burial ACCremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)	Da	te 2	20c. Location	- City or To	wn, State	
ant: if ury or		4 Donation 5 □Other (Specify) Uneer IIIIOUTT Celle Let'y	10-31	The second second			Marylar	ıd
any inj		21. Annature of Funeral Sarvice Ucensee 22. Name and Address of Facility Charles 650		ell-Wieck Road Balt				
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or hear failure. List only one cause on each line.	as cardiac or	respiratory arre	est,		Approximate Interval Betwee Onset and De	en eath
ysician Medical		Immediate Cause (Final disease or condition resulting in death)  Obesity  Due to (or as a consequence of):						
aminer								
sit	Iner	Sequentially list conditions, if any, leading to immediate cause. Erter Underlying Cause (Disease or injury						
al-tran	Examiner	resulting in death) Last  C.  Due to (or as a consequence of):						
hysicien and the burial-transit	cal	d					_	
g p	Med	IF FEMALE: 230 If year outcome of programmy					_	-
To the Funeral since.  To the Funeral birector: After this centificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	by Physician/Med	23b. Was decedent pregnant in the past 12 months?  1				ate of delive onth	Day Ye	ar
signed b d be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	t I.	23e. Did tob	./		ne cause of dea	
shoul	Completed			24a. Was an	1 24b.	Were auto	psy findings av	/aılal
ite has	omo			autopsy perform Yes 2	ned?	prior to cor death?	mpletion of cau 2□ No	SO C
ertifica actor, p	BeC	examiner/	ce of Death (	Check only one				
this c	은	XXYes 2 No Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ N		e 5 🗆 Reside			SCENE	
th. : After s funer	Certification:	27. Manner of Death  1  Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28b. Time of Injury Work?  1  Yes 2		d. Describe no	w injury occur	1100		
er death. rector: Atler this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as if	tifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28	If. Location (Str. City or Town	eet and Numi	ber or Rura	l Route Numbe	э <i>г</i> ,
led in								
n 24 no he Fune sletely fi	Medical	29a. Certifier  (Check only one)  1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date a 2☒ Medical Exeminer: On the basis of examination and/or investigation, in my opinion, deand manner stated.	and place, an eath occurred	d due to the ca	use(s) and m ite and place,	anner as st and due to	ated. the cause(s)	
To the	Me	29b. Signature and title of certifier 29c. License number OCME	r	29	d. Date signe	ed (Month,	Day, Year)	
		Mornie The Jack ins	C4 1		ctober			10'
		30, Name and addless of person who completed cause of death (Item 23a) (Type, Print) 111 Penn S	street	Balti	more,	Maryl	and 212	ω.
St	ate	31. Date filed (Month, Day, Year)  32. Patrar's Signature						
Regist	trar	OCT 3 1 2005						

O

State Registrar

31. Date filed (Month, Day, Year) OCT 2 5 2005

THEODORE Miking . Registrar's Signature.

State of Maryland / Department of Health and Mental Hygiene 115

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 35024

1. Decodent's Name (First, Middle, Last)  2. Seath (First)  3. Decodent's Name (First)  4. Decodent's Name		1 - For State Registrar	C	ertificate of	Death		Rag. No.	0 0	
46. Cay, Town or Location of Death 47. Age (In yrs. last brinday) 46. Cay, Town or Location of Death 46. Cay, Town or Location of Death 46. Cay, Town or Location or Location or Location or Location or Location of Death 46. Cay, Town or Location or Lo									Time of Death
S. Social Security Number   S. Sex   S. Age (in yrs. last principle)   Elementary		Francies D. A	lexander			N 1 1	. 0 /	2005	3015 M
\$ Social Security Number   S. Sex   7. Age (in yrs. last birmhost)   ff Under 1 Yes.   Months   Days   Hours   Min.   02° 25° 1935   9. Bightplace (State or Foreign Months)   Days   Hours   Min.   02° 25° 1935   9. Bightplace (State or Foreign Months)   Days   Hours   Min.   02° 25° 1935   9. Bightplace (State or Foreign Months)   Days   Hours   Min.   02° 25° 1935   9. Bightplace (State or Foreign Months)   Days   Hours   Min.   02° 25° 1935   9. Bightplace (State or Foreign Months)   Days   Hours   Min.   02° 25° 1935   9. Bightplace (State or Foreign Months)   Days   Hours   Min.   02° 25° 1935   9. Bightplace (State or Foreign Months)   Days   Hours   Min.   02° 25° 1935   9. Bightplace (State or Foreign Months)   Days   Da		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death		4c. County	of Death	
State   Stat		Memorial Hospital		East	JC		Ta	lbot	
Usual Residence of Decedent   108. State   106. County   106. City, Town or Location   106. Inside City Limits   106. Inside City Limits   106. Inside City Limits   106. Street and Number   106. Street and Number   106. Zep Code   20.88.1.4   106. Street and Number   106. Zep Code   20.88.1.4   106. Street and Number   106. Zep Code   20.88.1.4   20.88.1			70	Months Days		8. Date of Bir (Month, Da	rth ay, Year)	Country)	(State or Foreign
Md. Montgomery    10e. City, Town or Location   10e. City, Code   20814   U.S.   11. Merital Status   12. Wisa Dependent of Hispanic City or No. In the Code   10e. City, Class, Merical Property   10e. City, Class,		578 48 1300	Yrs.			02 25	1935	MD	
Md. Montgomery  Bethesda Md  12 Yes 2 No  76 20 Old Georgetown Road  10f. Zip Code 20 81 4  11. Marital Status  1   Marital Status  1   Never Married 2   Marned 3   Michowed 4   Downced 4   Downced 4   Downced 4   Downced 4   Downced 5   Michowed 4   Downced 5   Michowed 4   Downced 5   Michowed 5   Mi			10a City Town as	1				10d	Incide City Limite
10e. Street and Number 7620 Old Georgetown Road  10f. Zip Code 20814  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Hirtys, Specify, Colonian, Mexican Pushfo Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Hirtys, Specify, Colonian, Mexican Pushfo Rican, etc.) 11. News Marital 2□ Marined 3□ Wildowed 4 © Divorced 4 © Divorced 4 © Divorced 11 Yes 2 © No Specify: White 9 1 1 Yes 2 © No Specify: White 9 1 1 Yes 2 © No Specify: White 9 1 1 Yes 2 © No Specify: White 9 1 1 Yes 2 © No Specify: White 9 1 1 Yes 2 © No Specify: White 9 1 1 Yes 2 © No Specify: White 9 1 1 Yes 2 © No Wildowed Completed (Give kind of Work done during most of working 1 No Not Ture Hirtigal Section 1 1 Yes 2 © No Not Ture Hirtigal Section 1 Yes 2 © No Wildowed Completed (Give kind of Work done during most of working 1 Not Not Ture Hirtigal Section 1 Yes 2 © No Wildowed Completed (Give kind of Work done during most of working 1 Not Not Ture Hirtigal Section 1 Not Ture Hirtigal Sectio			Toc. City, Town or		1 7 2	-			
11. Marital Status	2	Md. Montgomery		Bet	nesda M	d			X 162 2 INC
11. Marital Status 12. Marital Status 13. Marital Status 14. Marital Status 14. Marital Status 15. Decedent Status 16. Marital Status 16. Specify: White 16. Marital Status 16. Decedent Status 16. Nor Loss viewed. 16. Nor Loss vi	<u> </u>	10e. Street and Number			•		10g. Citizen of	What Country?	
1   Never Married   2   Marred   1   Yes   2   No   1   Yes   2   No   3   Widowed   4   Dworced   1   Yes   Give   Year or Dates:   1   Yes   2   No   Specify:   Specify:   White   15. Decedent's Education   (Specify only highest grade completed)   (Give kind of work done during most of working   16b. Kind of Business/Industry   Medicine   17. Father's Name (First, Middle, Last)   Phytical Asst.   18. Mother's Name (First, Middle, Maiden Sumame)   Medicine   19a. Informant's Nama-Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   Phytical Asst.   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   20a. Method of Disposition   1   Bural 2   2   Cremation 3   DRemoval from State   20b. Place of Disposition (Name of Basic Print)   20b. Place Print)   20b. Place Print)	5	7620 Old Georgetown	Road	2081	4		U.	S.	
1   Never Married   2   Marred   1   Yes   2   No   1   Yes   2   No   3   Widowed   4   Dworced   1   Yes   Give   Year or Dates:   1   Yes   2   No   Specify:   Specify:   White   15. Decedent's Education   (Specify only highest grade completed)   (Give kind of work done during most of working   16b. Kind of Business/Industry   Medicine   17. Father's Name (First, Middle, Last)   Phytical Asst.   18. Mother's Name (First, Middle, Maiden Sumame)   Medicine   19a. Informant's Nama-Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   Phytical Asst.   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   20a. Method of Disposition   1   Bural 2   2   Cremation 3   DRemoval from State   20b. Place of Disposition (Name of Basic Print)   20b. Place Print)   20b. Place Print)	<u> </u>	11 Marital Status 12. Was Decedent	Ever in U.S. 1	3. Was Decedent of H	lispanic Origin? (S	pecify Yes or No	o- 14. Rac		ndian,
Specify of plates   Specify   Spec	3	Armed Forces?	No	If Yes, specify Cuba	an, Mexican, Puerti	Hican, etc.)	Bla	ck, White, etc.	
15. Decedent's Education   15. Decedent's Education   16a. Decedent's Usual Occupation   16b. Kind of Business/Industry   16b. Mind of Work done during most of working   16b. Kind of Business/Industry   16b. Mind of Work done during most of working   16b. Kind of Business/Industry   16b. Mind of Work done during most of working   16b. Kind of Business/Industry   16b. Mind of Work done during most of working   16b. Kind of Business/Industry   16b. Mind of Work done during most of working   16b. Kind of Business/Industry   16b. Mind of Work done during most of working   16b. Kind of Business/Industry   16b. Mind of Work done during most of working   16b. Kind of Business/Industry   16b. Mind of Work done during most of working   16b. Kind of Business/Industry   16b. Mind of Work done during most of working   16b. Mind of Work done during most of Working   16b. Mind of Work done during most of Work done during most of Working   16b. Mind of Work done during most of Working   16b. Mind of Work done during most of Working   1	Ż	II Yes. Give		1 ☐ Yes 2x2 No	Specify:		Specif	y: Whit	:e
Elementary/Secondary (0-12)	2		16a. De	cedent's Usual Occup	pation		16b. Kind of B	usiness/Indust	ry
12 5± Phylical Asst.  18. Mother's Name (First, Middle, Last) Adolph More  19a. Informant's Nama/Relationship (Type, Print) Delores M. Kennedy  20a. Method of Disposition 1 Bural 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22b. Place of Disposition (Name of commercials) 22c. Name and Address of Facility Dashiell Funeral Service 322 East Ave. Easton, Maryland 21601  23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death Crematical Cause (Final disease or condition resulting in death)  25d. Use tilarly liet conditors. 27d. Interval Between Onset and Death Crematical Cause (Final disease or condition resulting in death)  27d. Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death Crematical Cause (Final disease or condition resulting in death)  27d. Part Enter Underlying Cause (Disease or injury that initiated events resulting in death)  27d. Part Enter Underlying Cause (Disease or injury that initiated events resulting in death)  27d. Due to (or as a consequence of):  27d. Due to (or as a consequenc	i e		life	ive kind of work done a.  DO NOT use retire	during most of wor d)	king			
Adolph More    Pal Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)			0+)	Phyical	Asst.		Med	ıcıne	
199. Informant's Nama/Relationship (Type, Print)  190. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  190. Delores M. Kennedy  20a. Method of Disposition 1 □ Bunial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility Dashiell Funeral Service 32. Rank and Address of Facility Dashiell Funeral Service 32. Rank and Address of Facility Dashiell Funeral Service 32. Rank and Address of Facility Dashiell Funeral Service 32. Name and Address of Facility Dashiell Funeral Service 32. Rank and Address of Facility Dashiell	9	17. Father's Name (First, Middle, Last)			18. Mother's Nan	ne (First, Middle	, Maiden Suman	n <i>e)</i>	
Delores M. Kennedy  9059 Grove Ridge Ave. Las Vegas, NV 89148  20a. Method of Disposition  1	0	Adolph More'			Fra	nces	Mason		
20a. Method of Disposition    Burial   2   Cremation   3   Removal from State	-	19a. Informant's Name/Relationship (Type, Print)	19b. Ma	ailing Address (Street	and Number or Ru	ral Route Numb	per, City or Town,	State, Zip Cod	de)
20a. Method of Disposition    Burial   2   Cremation   3   Removal from State		Delores M. Kennedy	90	59 Grove	Ridge	Ave. L	as Veg	as, NV	89148
Salisbury Crematory 10/11/05   Salisbury		20a. Method of Disposition	20b. Place of Dis	sposition (Name of					
21. Signature of Funeral Service  22. Name and Address of Facility Dashiell Funeral Service  322 East Ave. Easton, Maryland 21601  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  25a. Use that if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death)  25a. Use to (or as a consequence of):  25a. Use of delivery  Month  Day Year		1 Burial 2 Cremation 3 Removal from State	Colinatery, o			0/11/0	E C-1	iahuru	7
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Interval Between Onset and Death  Interv		En Lashe	AY			<u> </u>			
Immediate Cause (Final disease or condition resulting in death)  a. CEREBRAL EDEMA  Due to (or as a consequence of):  RESPIRATORY FAILURS  Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  CARDIAC PREST  Due to (or as a consequence of):  CA		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each li	d the death. Do not ine.	enter the mode of dyir	ng, such as cardiac	or respiratory a	arrest,	Int	erval Between
Due to (or as a consequence of):  PESPIPATORY  Due to (or as a consequence of):  PESPIPATORY  Due to (or as a consequence of):  PESPIPATORY  Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  CARDIAC PREST  Due to (or as a consequence of):		Immediate Cause (Final disease or condition	REBR	AL ED	EMA				Sot and Doam
Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  CARDIAC PREST  Due to (or as a consequence of):  CARDIAC PREST  Due to (or as a consequence of):  d.  IFFEMALE: 23b. Was decedent pregnant in the past 12 months?  1   Live birth 2   Fetal death   3   Ectopic pregnancy   Month   Day   Year   Construction   Year   Construction   The past 12 months?				_					
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Due to (or as a consequence of):  d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Due to (or as a consequence of):  23c. If yes, outcome of pregnancy 1 Dive birth 2 Direct death 3 December 1 Direct (specific)  4 Direct of the past 12 months?  4 Direct of the past 12 months?  5 Direct of the past 12 months?		cause. Enter Underlying Cause (Disease or injury	RDIAC	ARR	EST				
d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Dive birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 1 Proport of the past 12 months?	Xar	that initiated events c.		-					
d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1   Fetal death   2   Fetal death   3   Ectopic pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   Month   Day   Year   A   Pregnant at time of death   5   Other (specify)									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 1   Dregnant at time of death 5   Other (specify)  4   Pregnant at time of death 5   Other (specify)	ŭ	d							
23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome or pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Year	Σ	IF FEMALE:							
4 Pregnant at time of death 5 Other (specify)	an/	23b. Was decedent pregnant  1 Live birth	2 Fetal death		у				y Year
	<u> </u>	1 Yes 2 No	t time of death	5 Other (specify)					

Physician /Medical **Examiner** 

use as the burial-transit

Completed by

Be

Certification: To

requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "nature eny Injury or other traumatic event, the Medical once."

FRANCIES ALEXANDER

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown

24a. Was an

2 1 Yes 26. Place of Death | Check only one

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 In atient 28a. Date of Injury (Month, Day Year) 5 Pending investigation

30. Name and address of person who completed cause of de tem 23a) (Type, Print)

28b. Time of 28c. Injury at Work?

2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Natural 2 Accident

3 Suicide

4 🗌 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

6 Could not be determined

29d. Date signed (Month, Day, Year)

To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifics completely tilled in by the funeral director.

MALIK 31. Date filed (Mon 1) (A) Y4+1)2 2005

EASTUN

MEMUHAL HOSP, EASTON, MD

State Registrar

		For State Registrar		partment of Health and ertificate of Death	Mental Hygien	The second second	35025
Physi		1. Decedent's Name (First, Middle, Las. Stephen	Ackerman		2. Date of Death Month	Day Year	3. Time of Death 5 19:10 PM
/Med Exam		4a. Facility Name (If not institution, give Shady Grove Hosp		4b. City, Town, or Location of Dea Rockville		c. County of Dea	
Funera Directo		5. Social Security Number 6. Se		ay) If Under 1 Year If Under 24 Hrs	8. Date of Birth	9. Bir Co	thplace (State or Foreign ountry)
Maryland f ehow	or	Usual Residence of Decedent  10a. State 10b. County  DC	10c. City, Town or Washing				10d. Inside City Limits 11√2 Yes 2 □ No
with the Page or 28a-	Direct	10e. Street and Number  1830 Plymouth Str	oot Mu	10f. Zip Code 20012	_	Citizen of What Co	ountry?
DEIKITMOFE, IMETYIEITIC Z.I.Z.I.3-UUJO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Exertical marked that at	y Funeral Director	11. Marital Status 1 Never Married 2 Married		3. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Puer 1 \( \subsection \) Yes 2 \( \subsection \) No \( Specify: \)	Specify Yes or No-	14. Race - Ame Black, Whit	te, etc.
Maryiand ZIZI3-UU30 d 2 should be filed within 72 hours at the and Mental Hygiene. 27 is marked other then "natural", or traumatic event, the Medical Exercit	Completed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation 16a. De (G) (G) College (1-4or 5+)	ocedent's Usual Occupation live kind of work done during most of wo e. DO NOT use retired)	orking	Kind of Business	/Industry
filed wi Hygien other th	Be Con	17. Father's Name (First, Middle, Last)	5+ Pro	gram Planner 18. Mother's Na	Fed me (First, Middle, Maide	leral Gov en Sumame)	vernment
hould be d Menta narked natic ev	To B	Edward Ackerman  19a. Informant's Name/Relationship (7	anna Print)	Mary	Tobin	or Tours State	Zin Codol
y IVICA and 2 si salth an n 27 is n ar traur		Fran Abbott / Dau	ghter 141	Milliken Creek Dr	. Napa, Cal	ifornia	94558
Deficiency of the page of an apportunit of them mportunit if them in the page of the page	5	20a. Method of Disposition  1	Removal from State 20b. Place of Di cometery, C Cedar 1	sposition (Name of crematory or other place) Hill Cemetery Oct	Date 200.	tland, M	Town, State
permit Depart Impor		21. Signature of Funeral Service Licens	Sugge	22. Name and Address of Facility Jo 5130 Wis. Ave. NW	Washington,		
Physicial /Medica Examine	l	Immediate Cause (Final disease or condition resulting in death)	lications that caused the death. Do not one cause on each line.  a	enter the mode of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death 2 Y hours
icate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if dry, teaching to mineral accase. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a consequence of):  d.				
The law requires that the death certificat the law requires that the death certificat the has been signed by the attending phyage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of de Month	livery Day Year
quires that n signed b	b	Part II. Other significant conditions or	ontnbuting to death but not resulting in th	e underlying cause given in Part I.			o the cause of death?
VICAL DECOLOS, aician: The law requires I certificate has been signe lirector, page 2 should be	Completed				24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
Physician: The This certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☑Inpatient 2 ☐ ER/Outpa	Othor	eath (Check only one)  Home 5 Residence	6 □Other (Spe	icity)
tune	ation: T	27. Manner of Death  1-Autural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year) 28b. Tim	e of 28c, Injury al	28d. Describe how in		C.I.Y.
s effer death.  al Director: Affe	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street a City or Town, Sta	and Number or R ite)	ural Route Number,
To the Hospital or Attend within 24 hours effer death To the Funeral Director: completely filled in by the	edical (	29a. Certifier to Certifying Physics (Check only one) 2 Medical Example 1	vsician: To the best of my knowledge, d iner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occ	e, and due to the cause curred at the time, date a	s) and manner as nd place, and du	s stated. e to the cause(s)
vithin To th comp	Me	29b. Signature and title of certifier	gonto Mi	29c. License number 6 / 5 4 9	29d. C	Date signed (Mont	
		30. Name and address of person who o	ompleted cause of death (Item 23a) (Ty しとアロッカュ リョウ1	pe, Print) Modical Center Di	. Bockville	a. MO 201	950
Regis	tate strar	31. Date filed (Month, Day, Year)  OCT 1 4 26	32 Registrar's Signature				

State of Maryland / Department of Health and Mental Hygiene 35026 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Oct 25, 2005 2:00am <sup>м</sup> Bragg Joseph Eugene /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Allegany Cumberland Villa Nursing Center Cumberland 8. Date of Birth (Month, Day, Apr 21, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F Days Hours MD 78 1927 Director 212-24-0151 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits d other then "neturel", or Items 23e or 28e-f show event, the Modical Exemple must be notified at Bedford PA Bedford 1 ☐ Yes 2 ☐ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2241 Evitts Creek Road 15522 USA permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then "neturel", or least any injury or other treumatic event Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white þ 3 Widowed 4 Divorced WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 disabled n/a 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Goldie Kidwell Bragg John Bragg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bedford PA 15522 Hazel Bragg wife 2241 Evitts Creek Road 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 10/28/2005 Centerville **Union Cemetery** PA 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. 108 Virginia Avenue; Cumberland, MD 21502 23a. Part Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition)

Metas Talia Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Melanoma **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transil attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) signed by the aid be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 20 No Hospital: Other: Certification: To 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide within 24 hours a To the Funerel L 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 25 2005 D003328V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 625 Kent Avenue Cumberland MD 21502 Sunil Gupta M.D. State Registrar

	1	For Stata Registrar	State of Maryland		rtment of F		-	giene Rog. No.	11115	35027
Physici	on	Decedent's Name (First, Middle, Last)					2. Date of De.			3. Time of Death
/Medic	al	MARGARITA d	e la ROSA de	BOWKS	4b. City, Town, o	r Logation of Do	OCT	13	2005 County of Dea	2:20 P M
Examin	er	NATIONAL NAVAL N		R		HESDA	alli		MONTGOM	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days			th		thplace (State or Foreign ountry)
Director		213-49-8652 Usual Residence of Decedent	67	Yrs.			OCT. 3		37	SPAIN
yland		10a. State 10b. County	10c. City	, Town or Loc	cation					10d. Inside City Limits
e Mar Sa-f st	Director	MD. PRINCE GE	EORGES	FT.	WASHINGT	ON				¹X Yes 2□No
with th		10e. Street and Number	~~		10f. Zip Code			10g. Citiz	zen of What Co	ountry?
death v	Funeral	9558 FORT FOOT  11. Marital Status	2. Was Decedent Ever in U.S	S. 13. V	Vas Decedent of H		(Specify Yes or No erto Rican, etc.)		SPAIN 14. Race - Ame	erican Indian,
after d		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		Yes, specify Cub	an, Mexican, Pu Specify:	erto Rican, etc.)		Black, Whit	te, etc.
be filed within 72 hours after death with the Maryland tal Hygiene. did other then "natural", or items 23a or 28a-f show event, I're Medical Exertiner.	d by	3 Widowed 4 Divorced	Year or Dates:							HITE
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tal Hy d othe	Bec	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle,	Maiden	Sumame)	
shoutd Ind Men	ဥ	RAFAEL de	e 1a ROSA	10h Mailin	a Address /Street		MILAGROS Rural Route Numbe		BELTRAN	
and 2 st ealth and n 27 is n		JAMES N. BOWKS/H					FT WASHI	·		
of Hear of Hear		20a. Method of Disposition	20b. PI	ace of Dispos	sition (Name of natory or other pla		Date		cation - City or	
Pages ment of l		1 ☐ Burial 2X Cremation 3 ☐ Re  '4 ☐ Donation 5 ☐ Other (Specify)	moval from State	CHAMBE	RS CREMA	TORY 10-	-15-2005		VERDALE	
parmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.  Department of Health and Mental Hyglene.  Importent: if item 27 is marked other then "natural" or items 23a or 28a-f show any injury or other traumatic event. If a Medical Examination and once.		21. Signature of Funeral Service Licenses	where MOOO	91 CH.	Name and Addre	ss of Facility UNERAL I	HOME & CR	EMAT	ORIUM, F	P.A.
		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ation that caused the death						, 110. 2	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	SEPSIS WITH	MILT	L ORGAN I	YSFUNCT	TON			Onset and Death
/Medical- Examiner		resulting in death)	Due to (or as a consequ							
	er	Sequentially list conditions, b.	COAGULOPATH							
cuted nd ransit	Examin	n any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	MYOCARDIAL	INFAR	CTION					
icate be executed physician and sthe burial-transit		resulting in death) Last	Due to (or as a consequ	ience of):						
polysicate by physical physica	dical	d.								
The could us, F.C. BOX 00100.  The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	n/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregna		1-			2	23d. Date of de	livery
death of atte	Physician/M	in the past 12 months? 1 🗆 Yes 2 🖾 No	1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown		Ectopic pregnanc Other (specify)	/			Month	Day Year
d by the	Phy	9 Unknown  Part II. Other significant conditions cont		ulting in the co	adorhina oguca an	os in Part I	23a Did t	obacco III	sa contributa t	o the cause of death?
wrequires that the deben signed by the should be detached	d by	Par II. Other significant conditions con	induling to death but not rest	nting in the ur	idenying cause gir	en m rant.				robably 4 (XUnknown
w requires been sign should be	mpleted						24a. Was	an	24b. Were a	utopsy findings available
The la	Comp						autor perfo	osy rmed? 2 <b>X</b> No	death?	completion of cause of s 2 No
	Be C	25. Was case referred to medical examiner?					eath (Check only o	ne)		
- > 0 0	은	1 ☐ Yes 2 反 No Ho		ER/Outpatien			Home 5 ☐ Resid			ecify)
ding h. After funer	tlon	1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Inju Wo M 1	yai k? Yes 2∐No	200. Describe i	now injury	y occurred	
r Attending ter death. irector: Afte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (S City or Tox			ural Route Number,
itel or rel Dir									<u> </u>	
To the Hospitel or Attending Phywithin 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	edical	29a. Certifier 1 X Certifying Physic (Check only one) 2 Medical Examin	cian: To the best of my know er: On the basis of examinat and manner stated.	wledge, death tion and/or inv	occurred at the tivestigation, in my o	me, date and pla pinion, death o	ace, and due to the ccurred at the time,	cause(s) date and	and manner as place, and due	s stated. e to the cause(s)
To th Within To th	Me	29b. Signature and title of certifier	-		29c, Licens	e number		29d. Date	e signed (Mon	th, Day, Year)
3		1 Mely M	0		A841	36 (CA)			14 8	
		30. Name and address of pers in who cor		23а) (Туре,	Print)		IAL NAVAL			NTER
St.	ate	SEAN A. MCKAY LT 31. Date filed (Month, Day, Year)	MC USN 32. Registrar's Signal	ture /	-4	DETHES	DA MD 208	209-2	2000	
Regist		OCT 1 7 2005	James H.	A DOGA	(L)					

State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND#10eperINF, 10/24/05, HWW, Moco Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 8:15 PM JOAN IRENE KAPALKO BALABAN October 2005 11 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Renaissance Gardens Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min Months 1 □ M 2 🖾 F 80 Yrs. Director Sept.24. 1925 Sharon, 208.16.3807 Usual Residence of Decedent with the Marylend 10c, City, Town or Location 10a State 10h County 10d. Inside City Limits 28a-f show injury or other treumatic event, the Madical Examiner; and be notified at 1 AYes 2 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 3152 10f. Zip Code 10g, Citizen of What Country? ŏ 238 <del>60</del> Gracefield Road, Apt #MS-211 20904 U.S.A. death 1 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or iteme e filed within 72 hours after al Hygiene. other than "naturei", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 N Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) 5+ Years Elementary/Secondary (0-12) Education Science Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be life Department of Health and Mental Hy Importent: If Item 27 is marked oth any injury of other treumatic event once. Joseph Kapa1ko Mary Kapa1ko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn B. Durant/Daughter 3186 Sharp Road, Glenwood, Maryland 21738 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Ceme. 10/15/2005 \* 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 22. Name and Address of Facility
HINES-RINALDI FUNERAL HOME, INC.
11800 New Hampshire Ave, Silver Spring, MD 20904 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) End Stage Dementia Days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the burial P.O. Box 68760, Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate 2∏ No 1 TYes 1 Yes 2 🔀 No Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 1 ☐ Yes 2 🛣 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 XNatural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 the 29d. Date signed (Month, Day, Year) 29b Signature a 0 October 14, 2005 1004337 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD, 3110 Gracefield Road, Silver Spring, Maryland 20904 Karen Merritt, 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

2005

ΓY	BINGHA	1	FOR	tate of Maryland /	•			Mental Hyg	2005	35029
			- State Registrar Amend #1.Per MEC	) PGC 10-17-05 ar	Certi	ficate of L	eath eath	2. Date of Dea	leg. No.	3. Time of Death
*	Physicia	an	1. Decedent's Name (First, Middle, Last)  Marty Bing	<del>ham</del> Marty E	lmor	Bingha	am Jr.	Month	Day Yea	ur M
	/Medic	al					Location of Death		9, 2005 4c. County of D	0108 A
	Examin	er	PRINCE GEORGES HOSP	ITAL CENTER		CHÉVERLY	Z		PRINCE (	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b	N	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	7. Year) 5, 1959	Birthplace (State or Foreign Country)
	Director	-	577-90-1131	<sup>2□F</sup> 46	Yrs.			Apr. 2	5, 1959	Wash., DC
	iand ow		10a. State 10b. County	10c. City, To	wn or Local	tion				10d. Inside City Limits
	Mary B-f eth	tor	Maryland Prince G	eorge's		Temple	Hills			1 Ves 2 No
	or 284	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	•
	ath wi	rai	3138 Brinkley Rd	<u> </u>		5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	20748			ed States
36	within 72 hours after death with the Maryland iene. rthan "natural", or Iteme 23a or 28a-f ehow then "Madical Examination at the Madical Examination at the	by Funerai	11. Marital Status  1  Never Married 2  Married  3  Widowed 4  Divorced	Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates:		s Decedent of His es, specify Cubar Yes 2K No	spanic Origin? (S n, Mexican, Puert Specity:	pecify Yes or No- o Rican, etc.)	Black, W	
Maryland 21215-0036	72 hou natura dical E		15. Decedent's Educati	on   16		nt's Usual Occupa	ition uring most of wor	tina	16b. Kind of Busine	ss/Industry
215	within 7, iene. then "n	Completed		College (1-4or 5+)	life. DO	NOT use retired)	)	King		
21		Con	12th			Post 0		no /First Middle	Gov Maiden Sumame)	vernment
and	2 2 0 0	Be	17. Father's Name (First, Middle, Last)  Marty E. Bingha	am. Sr.			18. MOUNETS NAT		e Dickerso	on.
Ž	s 1 and 2 should t f Health and Ment Item 27 is marked other traumatic	ဥ	19a. Informant's Name/Relationship (Type,		9b. Mailing	Address (Street a	nd Number or Ru	<u>-</u>	r, City or Town, Stat	
	1 and 2 ; Health ar tem 27 is		Marty E. Bingham,	Sr./Father	1	914 Q St	., S.E.	Wash., I	OC 20020	
ore,	of Hea of Hea f Item		20a. Method of Disposition 1	20b. Place ceme	tery, crema	ion (Name of tory or other place		Date	20c. Location - City	or Town, State
Ĕ	Pag ment tent: I		4 □ Donation 5 □ Other (Specify)	Maryl			Cem. 10/		tion and the same of the same	enham, MD
Baltimore,	permit. Pages 1 Department of H Important: if Ite eny injury or ot once.		21. Signature of Funeral Service License	ewart III			nning Ro	l., N.E.	Wash., DO	
*			23a. Part 1. Enter the disease, or complicat shock, in heart failure. List only one of	ions that caused he death. D cause on each line.	o not enter	P-	44.00	1		Approximate Interval Between Onset and Death
	Physician		Immedia Ca se (Final disease of condition resulting in 1 th)	Complicat	TOUS	0) nu	weigh	& Three	res	
	/Medical Examiner		Toolaing Interest in	Due to of as a consequence	ce of):	-	· ·	U		
		er	Sequentially list conditions, if any, leading to immediate b. –	Due to (or as a consequence	ce of):					
	outed id ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events  c							
o o	be executed sicien and burial-transit	Exe	resulting in death) Last	Due to (or as a consequence	ce of):					
8760,	icate be executed physicien and s the burial-transit	dical	d							
9		/Mec	IF FEMALE: 23c	If yes, outcome of pregnancy					23d. Date of	dolivory
Вох	death certifi e attending   ed for use as	Physician/Me	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death		ctopic pregnancy Other (specify)			Month Month	Day Year
0	at the de by the a tached	hysi	1  Yes 2  No 9  Unknown	9□ Unknown				-		
S, D	es tha igned l	by P	Part II. Other significant conditions contrib	outing to death but not resulting	g in the und	erlying cause give	n in Part I.			e to the cause of death?
ord	w require been sis						-	1 U	/es 2/2/No 3[	Probably 4 Unknown
Records,	a 8 2	Completed						24a. Was autop	an 24b. Were esy prior rmed? death	autopsy findings available to completion of cause of
al F								1 X Yes	2 □ No → 3	
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1  Yes 2  No Hos	pital: 1 ∭inpatient 2 ☐ ER/	Outpatient	3□ DOA Othe	ar.	ath Check only o	ne) dence 6 ⊟Other (5	δηρετήν)
of		<b>-</b>	27. Manner of Death		o. Time of Injury	28c. Injury Work		28d. Describe h	now injury occurred	1 1
sior	Attending I r death. ector: After by the funer	atio	1 Natural 5 Pending investigation		NK		Yes 2 XNo	los u	podestic	
Division	or Attendated after death	Certification:	3 Suicide 6 Could not be determined	<ol> <li>Place of Injury - At home, building, etc. (Specify)</li> </ol>	farm, stree	t, factory, office		28f. Location (S City or Tox	Street and Number of vn, State) Allow	How Ro
	Hospital 24 hours a Funeral C		29a. Certifier 1 ☐ Certifying Physic	ian: To the best of my knowled	a a death o	occurred at the tim	e date and place	and due to the	rause(s) and manner	co. MD
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai	(Check only one) Medical Examiner	On the basis of examination and manner stated.	and/or inve	stigation, in my op	pinion, death occu	irred at the time,	date and place, and	due to the cause(s)
	To th within To th comp	Me	29b. Signature and little of centier	110		29c. License	number		29d. Date signed (M	onth, Day, Year)
À	12		XIIIA	VVI		0.0	.M.E		OCT. 9,	2005
R	-(2)		30. Name and address of person who comp				BAT.TTMO	RE MADVI	AND 21201	
	0.00 Ct	ate	31. Date filed (Month, Day, Year)			-			"TAN 7T70T	
	Regist		OCT 1 7 2005	2. Registrar's Signature	Grad	E)				

		1		partment of Health and Meartificate of Death	ental Hygier	CHIL	3503I
	Physicia		1. Decedent's Name (First, Middle, Last)  JOSEPH WOODALL BEDWELL		2. Oate of Death Month OCTOBER	23 2°ear 2°00	3. Time of Death 5 4:30p M
	/Medic Examin	_	4a. Facility Name (If not institution, give street and number)  Chester River Manor	4b. City, Town, or Location of Death Chestertown	4	4c. County of Death Kent	
	Funeral Director	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 220−28−0464 11€ 79 Yrs.	/) If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Yea Apr 21 1	9. Birth 926 Mar	nplace (State or Foreign unity) Yland
			Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I				10d. Inside City Limits 1   1   1   1   1   1   1   1   1   1
	ith the Ma or 28e-f	Director	MD Kent Worton  10e. Street and Number  10733 Horseshoe Lane	10f. Zip Code 21678		Citizen of What Co	untry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deptiment of Health and Mental Hyglene. Deptiment of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel" or Items 23a or 28e-f show amy injury or other traumatic event, I'm M. Jical Eraninal must be notified at 2006.	by Funerai		3. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	ecify Yes or No-	14. Race - Ame Black, White	
21215-0036	within 72 hour sne. then "naturel	Completed b	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	cedent's Usual Occupation we kind of work done during most of workin DO NOT use retired)  ruck Driver	Ma	Kind of Business/ ryland ghway A	State
nd 2	be filed v tal Hygie d other t	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	den Sumame)	On •
Maryland	should bind Ment	၉	Charles Bedwell  19a. Informant's Name/Relationship (Type, Print)  19b. Ma	Illing Address (Street and Number or Rura	eth Hill NI Route Number, Cit		Zip Code)
nore, Ma	tges 1 and 2 at of Health a it from 27 is or other trains	1	20a. Method of Disposition 1	81 Station Rd. I position (Name of rematory or other place) er Cemetery 10/2	Date 20c.	MD. 216 Location - City or nesterto	Town, State
Baltimore,	perrit. Pa Dep rtmer Importent any injury		21. Sign to unral Se vo Licensee	22 Name and Address of Facility Calena Funeral H 18 West Cross S	ome of S	Stephen	L. Schaeck
	Priysician		23a. Part 1. Enter the disease, or complications that caused the death. Do not established, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a. Lun C. A. (C. A.)	enter the mode of dying, such as cardiac o			Approximate Interval Between Onset and Death  minths
), v	Medical Examiner be executed bhysician and sthe burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):				
Box 68760,	The law requires that the death certificate be tte has been signed by the attending physicit page 2 should be detached for use as the bu	an/Medicai	d.  IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 ∐Ectopic pregnancy		23d. Date of de	livery Day Year
o.	that the deat ed by the att detached fo	Physician/M	in the past 12 months?  1  Yes 2 No 9  Unknown  4 Pregnant at time of death 9 Unknown	5 Other (specify)			
rds, P	quires tha	þ	Part II. Other significant conditions contributing to death but not resulting in the	_			o the cause of death? robably 4 \( \subseteq Unknown \)
Records,	The law requir ate has been si page 2 should	Completed	CONGESTIVE HEART FAILURE	,	24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
Vital	certific rector,	Be	25. Was case referred to medical examiner?  1   Yes 2   No	Other 1- 2	h <i>(Check only</i> one) ome 5 ☐ Residence	e 6 DOther (Sou	acitu)
of	ding Phys h. After this funeral di	on: To	1  Yes 2 No	e of 28c. Injury at Work?	28d. Describe how i		ony)
Division	deat deat ctor: / the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No street, factory, office	28f. Location (Stree City or Town, S		ural Route Number,
	To the Hospitel or Ati within 24 hours after d To the Funeral Direct completely filled in by	Medicai C	29a. Certifier (Check only one)  15 Certifying Physicien: To the best of my knowledge, displaying the pasts of examination and/o and manner stated.	eath occurred at the time, date and place, r investigation, in my opinion, death occur	and due to the caus red at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
)	To th within To th comp	Me	29b. Signature and title of certifier  Mule un)	29c. License number D 004158	ļ	Date signed (Mon	th. Dey. Year)
	H		30. Name and address of person who completed cause of death (Item 23a) (Type Helen A. Noble, M.D. 122 S	<sub>pe, Print)</sub> peer Rd. Chester	town, Mi	D. 21620	0
	St Regis	ate trar	31. Date filed (Month, Day, Year)  32. Significants Signature	Sparke			
			UUI A U LUUJ I AARESTONIA	<i>f</i>			

			State of Maryland / [	Department of	Health and N	-	•	35032
			1 - State Registrar	Certificate of	Death		g. No. UUU	
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Philip Sterling Brooks Jr.			2. Date of Death Month October	Day Year 13 201	05 9:00A.M
	Examin	er	4a. Facility Name (If not institution, give street and number)		or Location of Death		4c. County of De	
			24 East Maple St.  5. Social Security Number 6. Sex 7. Age (In yrs. last bir		nkstown r   If Under 24 Hrs.	8. Date of Birth	100	ton County
	Funeral Director		17714 OFF	Yrs. Months Days	s Hours Min.	Month, Day, Dec 2	1928 Ca	irthplace (State or Foreign Sountry) alifornia
	yland		10a. State 10b. County 10c. City, Tow	n or Location				10d. Inside City Limits
	a Mar	ctor	Maryland Washington	Funkstown				Y☐ Yes 2 ☐ No
	vith th	Director	10e. Street and Number  24 East Maple St.	10f. Zip Code	21734	10	g. Citizen of What C United S	
	death with the Maryland ms 23e or 28e-f show rmst te notified at	Funeral	11, Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of		necify Yes or No-	14. Race - Arr	
0000	n 72 hours atter death with the Marylan "natural", or Hems 23e or 28e-1 show sciling Examinar must be notified at	by Fun	Amed Forces?  1 Never Married ZX Married  3 Widowed 4 Divorced  Amed Forces?  1 Xes 2 No 6-20-  1 Yes, Give Year or Dates: 5-4-47	TO THE ZENT		Rican, etc.)	Black, Wh	
	72 hou	ted		Decedent's Usual Occi (Give kind of work don- life. DO NOT use retir	upation	king 1	6b. Kind of Busines	s/Industry
2		Completed	Elementary/Secondary (0-12) College (1-4or 5+)			1	_	_
Z	ba filed withi tal Hygiene. d other than		17. Father's Name (First, Middle, Last)	Federal	Inspector	ne (First, Middle, M		cal Government
and		To Be	Philip Sterling Brooks Sr.			•	erine Daus	singer
3	should ind Men ind marke umatic	F		o. Mailing Address (Stree				
, Mar	s 1 and 2 shou I Health and M Item 27 Is mar other traumati		Mary Lou Bryan Brooks (wife)	24 East Map	ole St. Fu	nkstown M	Maryland 2	21734
ore				of Disposition (Name of ery, crematory or other pl			Oc. Location - City of	
Baltimore,	it. Pages rtment of rtant: If It njury or o			awn Cemeter				e Maryland
n n	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Licensee	22. Name and Add	stern Blvd	. N. Hage	erstown Ma	neral Home aryland 21742
	Physician /Medical Examiner	_	23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence Sequentially list conditions,	SCHEMIC I				Approximate Interval Between Onset and Death 2007
68/60,	icate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence c. Due to (or as a consequence d.					
O. Box	The law requires that the death certifica tie has been signad by the attending ph page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	n 3 □Ectopic pregnan 5 □ Other (specify)	су		23d. Date of di Month	elivery Day Year
rds, P	quires that n signad t uld ba dett	þ	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause g	given in Part I.		_	to the cause of death?  Probably 4 ☐Unknown
Records,	sician: The law require certificate has been si- irector, page 2 should b	ompleted				24a. Was an autopsy perform	prior to ed? death?	
Vital		e O	25. Was case referred to medical		26. Place of Dea	1  Yes 2 I		s 2 No
	nysici	To B	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Ou	utpatient 3 DOA	ther: 4 Nursing H	-		ecify)
ion of	nding Phath. ath. r: After thi e funeral			Time of 28c. Injury W		28d. Describe how		
Division	al or Attend s after death I Director: A d in by the f	ertification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	Э	28f. Location (Stre City or Town,		Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge 2 Medicel Exeminer: On the basis of examination are and manner stated.	nd/or investigation, in my	opinion, death occur	red at the time, dat	e and place, and du	e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. Licer	nse number	29	d. Date signed (Mor	nth, Day, Year)
,			3/Ma & Courts MD	Do	051395		10/17/	2005
, .			30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)				mo
2/1	1+1		31 Date filed (Month, Day Year) 32 Redictrar's Signature	MEDICAL C	Ampus 7	20 SUITE	=107, H	96515700N
	Sta Registi	rar	and manner stated.  29b. Signature and title of certifier  30. Name and address of person who comple of cause of death (Item 23a)  31. Date filed (Month, Day, Year)  OCT 19 2005  32. Registrar's Signature	Sperke				

		-	For State Registrar	State of Maryla		artment of H		-	iene	05	3501	3.3
			Decedent's Name (First, Middle, Last,	)				2. Date of Dear Month		Year	3. Time of D	)eath
	Physicia /Medic	al	David Leon B					Détaber	/2	2005	1115	PM
+ 7	Examin		4a. Facility Name (If not institution, give Washington C		ital	4b. City, Town, or Hage	Location of Dea erstown	th	4c. County of Death Washington County			ty
	Funeral		5. Social Security Number 6. Se:	AM 2DE	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, Day	Year)	Countr		Foreign
	Director		214-28-5428		75 Yrs.			Aug 9,	1930	Mar	yland	
	yland now		10a. State 10b. County	10c. C	City, Town or Lo	cation				10-	d. Inside City	
	a-f st	ctor	Maryland Washint	on	Hage:	rstown	<u>.</u>				1 Yes	2X No
	ith the	Dire	10e. Street and Number			10f. Zip Code	4540	1	0g. Citizen of		,	
	s 23s	ral	17426 Cindy Lane	12. Was Decedent Ever in	11 9 12 1		1740	Specify Ves or No-		d State		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Department of Health and Mental Hydiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evernment has notified a once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?  1 Xes 2 No If Yes, Give Year or Dates:	1	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🛂 No	Specify:	rto Rican, etc.)		ack, White, e	tc.	
21215-0036	2 hou	ted	15. Decedent's Edu (Specify only highest grad		16a. Dece	dent's Usual Occupa	ation	orkina	16b. Kind of I	Business/Indi	ustry	
21	ithin 7 18.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired h Machini	1)	,g	m	-1-2	M£~	
2	iled w Hygier ther th		12 17. Father's Name (First, Middle, Last)		Deric	II TACHILI		me (First, Middle,		cking l	MIG.	
and	uld be f fental h rked of tic eve	To Be	Charles C. Bartl	es, Sr.				C. Shank				
Maryland	12 shouh and M		19a. Informant's Name/Relationship (7) Hilda Mae Bartle			ng Address (Street a						
<u>.</u>	Healt Healt tem 2 other		20a. Method of Disposition		Place of Dispo	sition (Name of matory or other place			20c. Location			
E O	Pages ent of nt: If I		1 XBurial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State		urg Cemet	1	t 17 05	Leit	ersbur	g Mary	land
Baltimore,	permit. Departm Imports any inju		21. Signature of Funeral Service Licens		22	2. Name and Addres	ss of Facility	Douglas A	. Fier	y Fune	ral Ho	ome
rfo.	<b>₹</b> 0 <b>₹ 6 8</b>		23a. Part1. Enter the disease, or comp	- Pauly. I		1331 East					land 2 Approximate	
8	Physician		shock, or heart failure. List only o Immediate Cause (Final disease or condition	ne cause on each line.	A A		M(Q)	1	631,		Interval Betw Onset and Do	reen ,
8	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of);						77-109-1	<u>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</u>
		er	Sequentially list conditions, if any, leading to hims date cause. Enter Underlying	b. Due to (or as a cons	equanta of):				-			
	cuted nd ransit	Examiner	that initiated events	с.								
, 0	death certificate be executed e attending physician and of for use as the burial-transit	I Ex	resulting in death) Last	Due to (or as a cons	equence of):							
8760,	cate b	dlcal		d							- 1 -	
9 xc	leath certific attending p	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg					23d. D	Date of deliver	у	
.O. Box	the death the atter	by Physician/Me	in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown		Ectopic pregnancy Other (specify)			N	Month (	Day Y	ear
s, p	requires that the de neen signed by the hould be detached	y Ph	Part II. Other significant conditions co	ontributing to death but not r	esulting in the u	inderlying cause giv	en in Part I.	23e. Did to	bacco use co	ntribute to the	e cause of de	ath?
ords	w requires that s been signed to should be det	ed E						1 🗆 Y	es 2 🗆 No	3 Proba	ıbly 4 ∐Ur	nknown
Reco	e law has b	Completed						24a. Was a autop: perfor	sy	death?	sy findings a apletion of ca 2 No	vailable use of
ita	ysician: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?				26. Place of Di	eath (Check only or	ne)			
<u>&gt;</u>	0 to	ို	1 □ Yes 2 No		☐ ER/Outpatie		4   Nursing	Home 5 Resid			)	
uc	ing When	tlon:	27. Manner of Death  1. Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2∐No	28d. Describe h	ow injury occi	Tued		
Division of Vital Record	or Atten after deal Director in by the	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		home, farm, st cify)			28f. Location (S City or Tow		n <i>ber or Rural</i>	Route Numb	ner,
	Hospita 4 hours Funerat	edical C		ysician: To the best of my k iner: On the basis of exami and manner stated.								
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and mainted stated.	1	29c. Licens	e number		29d. Date sign	ned (Month, E	Day, Year)	
•			Hill H	au.	Lo	my.	1464	73	10	113/	05	•
			30. Name and address of person who o	completed cause of death (II	tem 23a) (Type	Print)	01	- 11		1	10 A.A	710
H-	-14+1		HIND How	32. Rugistrar's Sig	) 113	30 OF	HL C	1. Has	perst	own, I	M M	140
	Sta Regist		31. Date filed (Month, Day, Year)  OCT 18 2	32. Adjistrar's Sig	1. A.	pull		,	7			

State of Maryland / Department of Health and Mental Hygiene 05 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3 Time of Death 2. Date of Death **Physician** BERTHA MARIE BODILLY 2005 4c. County of Death Oct 11:00 AM /Medical 4a Fecility Name (If not institution, give street and number Genesis HealthCare - 1 4b. City. Town, or Location of Death Examiner The Pines Easton Talbot If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 4. Month Day, 1918 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 K Yrs. 163-10-6782 PA Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10h County 10a. State 10d. Inside City Limits r then "natural", or itame 23a or 28a-f show the Medical Exertir er must be notified at 1XYes 2 □ No Director TALBOT EASTON MD 10e. Street and Number 10g. Citizen of What Country? 21601 USA 610 DUTCHMANS LANE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE ģ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 is marked othe eny loury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LAURA WEAVER THOMAS CORBIN JONES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RONALD L. BODILLY/SON 30005 DOVER ROAD, EASTON, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State OXFORD CEMETERY 10/17/2005 OXFORD, MARYLAND ' 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA JOHN R. 200 S. HARRISON ST EASTON, MD 21601 MERCEROL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Kent testare ongestive) Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner crosdensis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit the attending physiclen and hed for use as the burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 menths? Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown s been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificete 1 ☐ Yes 2 ☐ No 1 Tes 2 No To the Hospitei or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No completely filled in by the 2 Accident Diractor: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours efter To the Funeral Dira 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner, stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) alon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DUTCHMANS CROWLEY MYD 610 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend Item #10g Per FH C850 12/09/05 of Death Reg(No.) U 5 Decedent's Name (/ 2. Date of Death Month **Physician** Bina Berkowitz 12:00 PM 10, OCT 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days Hours | Min. | JUL 2, 15 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2√ F 132/34/6897 1918 Poland Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show 1 □ Yes 2 No Directo Maryland Montgomery Rockville the 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code s 23a or 6121 Montrose Road 20852 Unavailable 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian marked other than "natural", or items matic event, the Medical Examination Black, White, etc. lited within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: þ 3 X Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I (Unknown) Orenstein (Unknown) ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i Department of Health Importent: If item 27 any injury or other tr once. Joe P. Scott/ Son 2911 Harris Ave., Silver Spring, MD 20902 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Riverside Cem. 10/12/2005 Rochele Park, NJ \*4 □ Donation 5 □ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility
Louis Suburban Chapels, INC. 13-01 Broadway, Fair Lawn, NJ 07410 a Parti. Enter the disease, or complications that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician LUTE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown The law requires that the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗷 No 3 Probably 4 Unknown been si Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 Tyes

Box 68760 0 Records, certificate has b irector, page 2 s of Vital or Attending Physicien: After th funeral Division

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 Natural
2 Accident

29a. Certifier

28a. Date of Injury (Month, Day Year) 5 Pending investigation

Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 28c. Injury at Work? 28b. Time of 1 ☐ Yes 2 ☐ No

Other: Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, State Registrar

Be

P

Certification:

Medical

Director:

within 24 hours after or To the Funerel Direct completely filled in by

To the

MD 32 Registrar's Signature Year) 14

26. Place of Death (Check only one)

		-	For State Registrar	State of	Maryland		artment of F		nd Mental Hy	giene Reg. No.	05	35036
	Physici	an	Decedent's Name (First, Middle						2. Date of De Month	Day 13	2005	3. Time of Death
1	/Medic	al	SHIRLEY  4a. Facility Name (If not institution	JEAN	JONES	CAL	4b. City, Town, o	r Location of	August		ZUU3	7:10A <sup>M</sup>
1	Examir	er	Magnolia Nursi		WOI)		Lanham	Location of	Death		ice Ge	
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. las	t birthday)	It Under 1 Year Months Days	If Under 24	4 Hrs. 8. Date of Bi	rth	9. Bin	thplace (State or Foreign
	Director		578-30-4828	1□ M 2 <b>XX</b>	79	Yrs.	Worth's Days	110013	Min. (Month, De	ry 24,	1926	WashingtonD(
	and *		Usual Residence of Decedent  10a. State 10b. County	,	10c. City, 1	Town or Lo	ocation					10d. Inside City Limits
	hours after deeth with the Meryland turel', or Iteme 23a or 28a-f ehow al Exeminar must be notified at	ō	Maryland Princ	e George	Lando	ver						1 TYes 2 □ No
=		Director	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Co	ountry?
		a D	11112 Webwood	Court			20706				d Sta	
	lteme Inerme	Funeral	11. Marital Status	12. Was Deced	es?	13.	Was Decedent of H If Yes, specify Cuba	lispanic Origi an, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	0- 14	Race - Ame Black, Whit	encan Indian, e, etc.
36	s in the state of	by F	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☑ Divorced	If Yes, Give			1⊡ Yes 2⊈No	Specify:		s	pecify: B	lack
21215-0036	d within 72 hours aff plene. ir than "neturel", or ine Madical Exem	bel		nt's Education	1	16a. Dece	dent's Usual Occup	oation	of working	16b. Kind	of Business	/Industry
215	within 7 ene. than "n he Mad	Completed	(Specify only night Elementary/Secondary (0-12)	completed) College (1-4		life.	kind of work done DO NOT use retire	d)	or working	1		Children's
2	Hygien Hygien ther th		Twe1th	( ant)		Heal	th Care A		's Name (First, Middle			C Government)
Maryland	2 2 2 2	Be	17. Father's Name (First, Middle, Lawrence P. Jos						erine Irene			
2	d 2 should it end Menion 7 le markettraumatic	၉	19a. Informant's Name/Relations			19b. Maili	ng Address (Street		or Rural Route Numb			Zip Code)
	1 and 2 a Heelth er tem 27 le		Kim Calloway/S	on		3416	Brinkley	Rd.,	Temple Hil	lls, M	arylaı	nd 20748
altimore,	ss 1 and of Heelth litem 27 r other t		20a. Method of Disposition  258 urial 2 ☐ Cremation		20b. Plac	e of Disponentery, crea	osition (Name of matory or other pla	ce) Au	gust 18,	20c. Loca	tion - City or	Town, State
Ë	Page ant: I		'4 □Donation 5 □ Other (S			rrect		2	2005	Clint	on, Ma	ryland
Bait	permit. Pages 1 Dapartment of H Important: If Ite any Injury or ot 2058.		21. Signature of Funeral Service	Licensee					Robert G.			
	40 = 4 Q		222 Part Enter the disease of	r complications that can	sed the death	Do not en	ter the mode of dvir	Hope K	d SE, Wash	lingto	n DC 2	20020 Approximate
> +	nysician /Medical	8	23a. Part1. Enter the disease, o shock, or heart tailure. Lis tmmediate Cause (Final disease or condition resulting in death)	a	Sof	00	ter the mode of dyn	ig, suar as c	ardiac or respiratory a			Interval Between Onset and Death
	Examiner				r as a conseque	nce on:						
	n =	ě	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Due to (or	as a conseque	nce of):						
ph	be executed sician end burlei-trensit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c								
8760,	clan e	ũ	resulting in death) cast	Due to (o	r as a consequer	nce or):						
387	physics the t	dical		d								
Box 6	eath certific attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			-			230	d. Date of de	livery
m.	death e atte		in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnar	h 2 ☐ Fetal de nt at time of deat		□Ectopic pregnancy □ Other <i>(specify)</i> _	y 			Month	Day Year
P.O.	by the distance of the desired	hys.	9 🗆 Unknown	9□ Unknov						_		
ords,	The law requires that the death certificate be executed to has been signed by the attending physician end hage 2 should be deteched for use as the buriel-trensit	2	Part II. Other significant condition	ons contributing to dea	th but not resulti	ng in the L	e Corre		200	Yes 2 1		o the cause of death?
		Completed							24a. Was auto perfo 1 ☐ Yes	s an opsy ormed? 2 2 No	death?	utopsy findings available completion of cause of
/ita	certifica rector, p	Be	25. Was case referred to medica examiner?	Haspital			Ott		of Death (Check only			
of o	Phyel this o	2	1 ☐ Yes 2 ☐ No  27. Manner of Death	1 ☐ Inj	Datient 2 Ef	VOutpatie	III JUA		sing Home 5 Res 28d. Describe			city)
0	ding Ph h. After th funerel	盲	1 ☑Natural 5 ☐ Pendi	/A footh	Day Year)	Injury	Wo	rk?` Yes 2 ∐ N				
Division	Attendli r deeth. ector: A by the fu	E Ca	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of	f Injury - At hom	e, farm, st	reet, factory, office			(Street and I	lumber or Ri	ural Route Number,
ā	s effe s effe el Dir	Certification;	4   Horricae	Daliding	g, etc. (Specify)				Oily of 70	, oldio,		
	To the Heepitel or Attending Physicien: within 24 hours eiter deeth. To the Funers! Director: After this certific completely filled in by the funers! director,	edical		ng Physician: To the b I Examinar: On the bas and manne	is of examination							
	Mithi To ti	Ň	29b. Signature and title of certific	(d. (c	//		29c. Licens	se number	9	29d. Date :	igned (Mont	h, Day, Year)
	10		30. Name and address of person  Don Yablonowitz				-	12 *-	nham Ma1	and of	706	
	C+	ate	31. Date filed (Month, Day, Year	L 25 D				اAL, Lai	nham Maryl	and 21	7/00	
	Regist		OCT 3 1	2005	gistrar's Signatur		still s					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death October 11, **Physician** 2005 Louis Thomas Cherone, Jr. 10:47P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Laurel Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□ F 48 218-66-4308 Yrs. Director April 9,1957 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits ir than "natural", or freme 23s or 28s-f show the Medical Examinar must be notified at Director Columbia 1 Yes 2 No Maryland Howard 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21045 United States 6972 Little Boots Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1□Yes 2XNo Specify Specify: Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self employed Automotive 12 nd 2 should be filed vith and Mental Hygie 27 is marked other for traumatic event, III other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 end 2 should be Department of Health and Mental Important: If Itam 27 is marked any injury or other traumatic evone. Louis Thomas Cherone, Sr. Eleanor Fae Jorden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann S. Cherone -wife 6972 Little Boots Columbia, Maryland 21045 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 10/15/2005 Silver Spring, Md. ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Lung Cancer 1 month /Medical Due to (or as a consequence of) 30 years Examiner Tobacco dependence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and s burial-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Be Completed by Physician/Medical the d guipt IF FEMALE esn . 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the e Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Prostate cancer 3 Probably 4 Unknown 1X Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 □ No Division of Vital 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after deat Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide within 24 hours a To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Timothy P. McClain, M.D. 321 Prince George Street Laurel, Maryland 20707 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 2005

		·	1 - For State Registrer	State of Marylan	id / Depa <i>Cer</i>	rtment of H tificate of I	lealth and Death		giene 0 0 5	35038		
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Muriel	Anita	Corbi	า		2. Date of De Month OC L	_	3. Time of Death 4:03p M		
	Examin		4a. Facility Name (If not institution, give s Holy Cross Ho			4b. City, Town, or Silve:	Location of Deat		4c. County of I	Death JOMery		
	Funeral Director		5. Social Security Number 6. Sex 053-22-7085	7. Age (In yrs. 79	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da	17. Year) 3/1925 B	Birthplace (State or Foreign Country) STOOKLYN, N.Y		
	Maryland -1 show lied at	tor	Usual Residence of Decedent		y,Town or Lo	Spring				10d. Inside City Limits 1 ☐ Yes 2 🚰 No		
	with the	I Direc	10e. Street and Number 2313 Manor Spri	ing Terrace		10f. Zip Code 2090	6		10g. Citizen of Wha	at Country?		
336	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "neturel", or Items 23a or 28a-f show imatic event, Ite Madical Exama har must be notified at	by Funeral Director		12. Was Decedent Ever in U Armed Forces? 1 Yes 2XN No If Yes, Give Year or Dates:	.S. 13. V	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 1 No	ispanic Origin? (S In, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		White, etc.		
1215-0036	vithin 72 hound.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give :	ent's Usual Occup kind of work done OO NOT use retired	during most of wo f)	rking				
Maryland 21		o Be Co	12 17. Father's Name (First, Middle, Last) Oscar Fleming				18. Mother's Na		, Maiden Sumame)			
	and 2 shoualth and N 27 is mai	3	19a. Informant's Name/Relationship (Ty, George S. Corbin									
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: if item 27 is marked eny injury or other treumatic evones.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State	emetery, cren inelaw	sition (Name of natory or other place IN Mem. F	1		Farmin	gdale, N.Y.		
Ball	permit. Depart Import eny inj		21. Signature Juneral Service Licer	elde	P) 9.	Name and Addre HILIP D 241 Col	.RINALD umbia E	I FUNE	RAL SERV lver Spr	ICE,P.A. ing,Md20910		
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heard allure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Asystole									
	/Medical Examiner	<u>.</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a consect Hyperlipi Due to (or as a consect	demia							
	ecuted and -transit	kamine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Hypertens Due to (or as a consec	ion							
68760,	ficate be executed physician and is the burial-transit	edical Examiner		Osteoarth	,							
P.O. Box 6	The law requires that the death certificate has been signed by the attending lagge 2 should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome of pregn. 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c	al death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of Month	f delivery Day Year		
	quires that to signed by ald be detail	by	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the ur	nderlying cause giv	en in Part I.	23e. Did t				
Division of Vital Records,		Completed							psy prior deat	r to completion of cause of th?		
Vita	Physicien: Th this certificate al director, pag	o Be	25. Was case referred to medical examiner?	lospital: 1 ☑ Inpatient 2 ☐	TEP/Outpation	t 3 DOA Oth		ath (Check only o		· · · · · · · · · · · · · · · · · · ·		
ion of	Attending Physicien: r death. ector: After this certification of the funeral director.	$\vdash$	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at k? Yes 2 □ No		how injury occurred	Race - American Indian, Black, White, etc.  Pecify: Black of Business/Industry  Lothing  Imame)  Armichael  Fown, State, Zip C20906  Liver Spring, MI  Ition - City or Town, State  mingdale, N.Y.  SERVICE, P.A.  Spring, Md20910  Approximate Interval Batween Onset and Death  Day  Year  Contribute to the cause of death?  No 3 Probably 4 Unknown  Cab. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  Contribute to the cause of death?  Cab. Were autopsy findings available prior to completion of cause of death?  Cab. Were autopsy findings available prior to completion of cause of death?  Cab. Were autopsy findings available prior to completion of cause of death?  Cab. Were autopsy findings available prior to completion of cause of death?  Cab. Were autopsy findings available prior to completion of cause of death?  Cab. Were autopsy findings available prior to completion of cause of death?  Cab. Were autopsy findings available prior to completion of cause of death?  Cab. Were autopsy findings available prior to completion of cause of death?  Cab. Were autopsy findings available prior to completion of cause of death?  Cab. Were autopsy findings available prior to completion of cause of death?  Cab. Were autopsy findings available prior to completion of cause of death?  Cab. Were autopsy findings available prior to completion of cause of death?  Cab. Were autopsy findings available prior to completion of cause of death?  Cab. Were autopsy findings available prior to completion of cause of death?  Cab. Were autopsy findings available prior to completion of cause of death?  Cab. Were autopsy findings available prior to completion of cause of death?  Cab. Were autopsy findings available prior to completion of cause of death?  Cab. Were autopsy findings available prior to completion of cause of death?		
Divis	i die o	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci		eet, factory, office		28f. Location ( City or To		or Rural Route Number,		
	e Hospital or 24 hours afte e Funerel Dir letely filled in I	edical	29a. Certifier 1 Certifying Physical Check only one) 1 Medical Exami	sician: To the best of my knoner: On the basis of examinating and manner stated.	owledge, death ation and/or inv	occurred at the tir restigation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) and manne date and place, and	ar as stated. I due to the cause(s)		
)	To the within 2.	Me	29b. Signature and title of certifier	DINO		29c. Licens D1 7						
	į		30. Name and address of person who co D.B.Patrick MD		m 23a)(Type, esvill	Print) e Rd.Si	lver Sp	ring,M	d 20910			
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature	de				A P.D. T. BEZ.		

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** ALICE NADINE CORDANI October 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Holy Cross Hospital Montgomery Silver Spring Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 🖾 F Yrs. 68 June 25, 1937 Kentucky 578.50.5234 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10b. County 10c. City, Town or Location 10a State ir than "natural", or itema 23a or 28a-f show the Medical Evantivar posts be notified at 1 1 Yes 2 No Rockville Directo Maryland Montgomery 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number U.S.A. 11504 Patapsco Drive 20852 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene important: If item 27 is marked othar than "natural; or itema 23a any injury opesites traumatic evant, it is Medical Examinar inserting. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: White 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 Specify: ğ 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cora Moore Worley Hood 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11504 Patapsco Drive, Rockville, Maryland 20852 Richard Alvin Cordani/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Fort Lincoln Crematory 10/18/05 Brentwood, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 New Hampshire Ave, Silver Spring, MD 20904 21. Signature of Funeral Service Licenses Nana Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failures. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Lung Cancer Physician /Medical Due to (or as a consequence of): **Examiner** Post Obstructive Pneumonia Sequentially list conditions, Tany leading to in module cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Acute Myocardial Infarction The law requires that the death certificate be executed usa as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🖺 No 4 Pregnant at time of death 5 Other (specify) P.O. | 9☐ Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part L 23e. Did tobacco use contribute to the cause of death? Records, þ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? 1 ☐ Yes 2 ☐ No 2 X No 1 ☐ Yes certificate Division of Vital Hospital or Attending Physician: 26. Place of Death (Check onl. one) Be 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3□ DOA 2 X No 0 1 Tes this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After Injury 5 Pending investigation 1 XNatural 1 🗌 Yes 2 🗌 No after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00063334 ruella 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Haval M. Saadlla, MD, 1500 Forest Glen Road, Silver Spring, Maryland 20910 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			For State Registrar	State	of Marylan	d / Depa <i>Ce</i>	artment rtificate	of H	ealth a	and M		Reg. No.	005	35040
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	Physicia /Medic		EDITH ANITA	A CUMB	ERBATCH						Octobe	r 11	2005	5:30 A <sup>M</sup>
	Examin		4a. Facility Name (If not institution	_					Location o				ounty of Death	
			Layhill Center						Spr				ntgome	
г	Funeral		5. Social Security Number 079–20–5300	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs.	last birthday) Yrs.	If Under Months	Days	If Under:	Min.	8. Date of Birt (Month, Da Sept. 2	y Year)	9. Birth	place (State or Foreign ntry)
Н	Director	-	Usual Residence of Decedent		101	113.					Sept. 2	5, 19	04 Bart	pados, B.W.I
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation			<del></del>		-		10d. Inside City Limits
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	the	rec	10e. Street and Number				10f. Zip	Code				10g. Citize	n of What Cou	ntry?
	3a o	0	90 Monroe Stre	et, Apt #	704		20	850				U.S	S.A.	
	death	Funeral Director	11. Marital Status		cedent Ever in U.	S. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Spe	city Yes or No	- 14.	Race - Ameri Black, White,	
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21215-0036	be filed within 72 hours after death with the Maryland at Hygiene. Hygiene id other than "natural", or teems 23a or 28e-f show event, the Medical Exate in a must be notified at	d by	3 XWidowed 4 ☐ Divorced	Year or	Dates:								Decily. D1	ack
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Ž	should be nd Mental i markad umatic ev	٦ و	19a. Informant's Name/Relations			19h Maili	na Address	/Street a			l Route Numbe			n Code)
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e)	Heal Heal em 2		20a. Method of Disposition	Lbaten/ 50		Place of Dispo					ate		tion - City or T	
0	de in of the state		1 XBurial 2 Cremation		ii State	emetery, crei te of				0/17	/2005	C+1177	er Spri	ng MD
Baltimore,	artme orteni injur		<ul><li>4 □ Donation 5 □ Other (S</li><li>21. Signature of Funeral Service</li></ul>		\ Ga	25	Name and	Addres	s of Facilit	lv	-			ing, mb
Ba	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If item 27 is marked eny injury or other traumatic a once.	a l	Nanny A	Vece	ti	H]  1:	INES-R 1800 N	INAI ew 1	DI F Hamps	UNER/ hire	AL HOME Ave, S	ilver	Spring	g, MD 20904
	death certificate be executed  Wedlical  e attending physician and id for use as the burial-transit	ical Examiner	23a. Part1. Enter the dise se, or shock, or head farture. List immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or minury that initiated events resulting in death) Last	b. Due to	each line.  bral Vas  o (or as a conseq  o (or as a conseq  o (or as a conseq	scular uence of): uence of):								Interval Between Onset and Death
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О.	s that ned b	by Pl	Part II. Other significant conditi	ons contributing to	death but not res	ulting in the u	inderlying ca	use give	n in Part I.		23e. Did to	obacco use	contribute to t	the cause of death?
r Sp	v requires been sign should be		Dementia, Ur	inary Tra	ct Infe	ction					101	res 2.2∰1	No 3 ☐ Prol	bably 4 Unknown
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sio	Attending r death. sctor: Atterby the fune	cati	2 Accident investi 3 Suicide 6 Could	gation not be			М		fes 2□			n		
Division	lor Atten after deatl Diractor:	Certification:	4 Homicide determ	nined 286. Pla	ce of Injury - At he ding, etc. (Specif		reet, factory	, office		1	28f. Location (3 City or Tox		Vum <i>ber</i> o <i>r Run</i>	al Route Number,
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	*		30. Name and address of person							. "				
			Lynne D. Digg					nue,	Sui	te #	206, Ke	nsing	ton, MI	J
	Sta Registi		31. Date filed (Month, Day, Year OCT 1	7 2005	Registrar's Signa	G A	anti							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 14, LUIS **CAMUS** OCT. H. 2005 8:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner **CASEY HOUSE** ROCKVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1**X**M 2□ F Yrs. MARCH 4, Director 212-96-7969 65 1940 CHÍLE Usuel Residence of Decedent with the Maryland 10a State 10c. City. Town or Location 10b. County 10d. Inside City Limits Show r then "neturel", or Items 23s or 28s-f shov the Medical Examiner must be notified at 1 Yes 2 □ No Director MONTGOMERY MD. GAITHERSBURG 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 526 HELENE ST. 20878 death v Funeral CHILE 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant if item 27 is marked other then "neturel; or ite ury or other treatmatic event, the Madical Examinating other treatmatic event, the Madical Examina 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ INTERNATIONAL OFFICER I.D.B. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( ROBERTO **CAMUS** P OLGA ROQUANT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a ltem 27 if other tr MARIA GLORIA CAMUS/WIFE 526 HELENE ST., GAITHERSBURG, MD. 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If it any Injury or conce. CHAMBERS CREMATORY 10-15-2005 RIVERDALE, MD. permit. 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P 21. Signature of Funeral Service Licensee 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 M00091 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** END STAGE DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) physicien and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Completed by Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery atter 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ned by the a 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, sign 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes X∏ No should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2**X** No Division of Vital Hospital or Attending Physicien: After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence MOther (Specify) HOSPICE Certification: To 1 ☐ Yes 2 No 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Injury 1 X Natural 5 Pending after death.

Director: Aff 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled in within 24 hours at to the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and 2 D41218 14 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARRISON, M.D. 6001 MUNCASTER MILL RD., ROCKVILLE, MD. 20855 CHARLES 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SORAL S Registrar

State of Maryland / Department of Health and Mental Hygiene 0 0 5 35142 Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 200<sup>5</sup>3 October 11, **Physician** TERESA В. CROCKETT 1:45AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Chase Year If Under 24 Hrs. HRC Manor Care Nursing Home Chevy Montgomery Birthplace (State or Foreign Country) 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 1 □ M 2 1 F 91 Director 16,1913 New York 092-09-0288 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show traumatic avant, the Medical Examiner roust be notified at 1 ves 2 No MD Chevy Chase Director Montgomery 10g, Citizen of What Country? 10f Zin Code 10e. Street and Number 5 8700 Jones Mill Road 20815 USA Itams 23a Pages 1 and 2 should be filed within 72 hours after death nent of Heatih and Mental Hyglene. Int: If item 27 is marked othar than "natural", or Items 23: Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: White 3 ☐ Widowed 4 ➡ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Teachers Aide School System 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Victoriano Bulnes <u>Maria Gonzalez</u> 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11509 Stonewood Lane, Rockville, MD 20852 Maria Crockett/daughter othar i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 5 Cedar Hill Cemetery 10/14/2005 Suitland, MD permit. Page Department of Important: If any injury or once. 22. Name and Address of Facility Cedar Hill Funeral Home, Inc. 21. Signature of Funeral Service Lizy see 4111 Pennsylvania Ave. Suitland, MD 20746 Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1 Immediate Cause (Final disease or condition resulting in death) Sepsis Syndrome Physician /Medical Due to (or as a consequence of): Aspiration Pneumonia Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed burial-transil Due to (or as a consequence of): Box 68760. the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Comfortcare, Advanced Dementia, Congestive Heart 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Failure, Failure to Thrive, Depression, Hypothyroidism autopsy performed? Yes 2 2 No has 1 ☐ Yes 2 ☐ No 1∏ Yes certificate Division of Vital Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 1 ☐ Yes 2 🗓 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After 5 Pending investigation 1 Natural 2 🗌 No 1 TYes death. 2 Accident Diractor: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 THomicide within 24 hours a To the Funaral D Medical 1K; Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and ture of certifier D53367 October 12, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10810 Darnestown Rd. Ste. 202 Gaithersburg, MD 20878 Rajan Shyamsundar, M.D. 31. Date filed (Month, Day, Year) . Registrar's Signature State OCT 1 7 2005 Registrar

		•	For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artmen <i>rtificat</i>			d Mental Hy	giene Reg. Ne.	005	35043
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	Examin	er	4a. Facility Name (If not institution,		TIN WATER	/		ocation of D			County of Deat	
	Euparal		SALISBURY REHAB  5. Social Security Number		ENTER (In yrs. last birthday,	If Under	1 Year	If Under 24	21804 Hrs. 8. Date of Bir	th	9. Birt	holace (State or Foreign
	Funeral Director		227-12-5636	<b>™</b> 2□ F	82 Yrs.	Months	Days	Hours N	02-05-	1923	Co	GINIA
	D .		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation						10d. Inside City Limits
	shon	5		ONTGO								1 ☐ Yes 2 ☐ No
	the M	ect	MD WIC	OMICO	SALISBUR	10f. Zip	Code	<del></del>		10a. Citiz	en of What Co	
	3a or		101 WOODCREST A	VENUE		1.00,120		1804				USA
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9	after or Ita	Fu	1 Never Married 2 Marrie		lomini	1 Tos, spo		Specify:	oono moan, etc./			HITE
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ATW Mar	12 sho h and 7 Is ma trauma	4	19a. Informant's Name/Relationsh BARBARA COLYAR			-			r Rural Route Numb NTER PARK			
CA	C = 14 F		20a. Method of Disposition	- DAUGHIER	20b. Place of Disp	osition (Na	ne of	-1	Date		ation - City or	
IE	00		1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☒ Other (Sp	3 □Removal from State ecify)ENTOMBMEN	cemetery, cre			1	-18-2005	HEBR	ON, MA	RYLAND
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F) @	permi Depar Impo any ir		1 fellsw	Helley					REET, SALI		,MARYL	AND 21804
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	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	0		Ð.	een			
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<u> </u>	sician: The la certificate ha irector, page								1 Tes	ormed? 2₽No	death?	2 19 No
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Ţ	g Phys ar this eral dir		27. Manner of Death	1  Inpatie			28c. Injury a Work?		ng Home 5 Resi			ciry)
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Division of Vital Becords	r Atte	ertification:	3 Suicide 6 Could n 4 Homicide determin	ot be ned 28e. Place of Inju- building, etc	ury - At home, farm, si	treet, factor	, office		28f. Location ( City or To		Number or Ru	ıral Route Number,
	Hospital or 4 hours afte Funeral Dire tely filled in b	O	00-0-0-	Bhaile Taile								
	To the Hospital or Attandi within 24 hours after death. To the Euneral Director: A completely filled in by the fu	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best of Examiner: On the basis of and manner sta	examination and/or in	th occurred nvestigation	at the time , in my opir	, date and p nion, death o	lace, and due to the occurred at the time,	date and p	ind manner as place, and due	to the cause(s)
_	To the P within 2 To the P complete	Me	29b. Signature and title of certifier	1 . /2		29	. License r	number		29d. Date	signed (Mont	h, Day, Year)
	Λ		DAY.	Mu		0	22	530	19	NI	12/0	•
	Grank		30. Name and address of person v	vho completed cause of d	eath (Item 23a) (Type	, Print)					-	
	-C NAM		UTLITAM ROBINS	, M.D. 200 C	IVIC AVE.	, SAL	SBUR	Y, MD.	21804			
	Sta Registr				ars Signature							
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ORIGINAL

			For State Registrar	State of Marylan		ment of Health		Hygiene Reg. No.	005	35044
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, La  AR RIFTT  4a. Facility Name (If not institution, give	ELIZABET		City, Town, or Location	Mod	of Death th Day	Year County of Death	3. Time of Death
	Funeral Director		5. Social Security Number 6. S Usual Residence of Decedent	Sex 7. Age (In yrs.		Under 1 Year If Undonths Days Hours	ler 24 Hrs. 8. Date (Mon	of Birth th, Day, Year),	9. Birth	place (State or Foreign ntry)
	death with the Maryland rms 23e or 28e-f show	Irector	10a. State 10b. County  W CO  10e. Street and Number	MICO 10c. Cit	y, Town or Location  ANTICO	on 3 KE Of. Zip Code		10g. Citi	zen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 📆 No ntry?
936	n 72 hours after death with the Marylan "naturel", or tlems 23e or 28e-1 show priced Ever in ret insist ke riculthod at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces?, 1	If Ye	Decedent of Hispanic Cos, specify Cuban, Maxic		or No-	14. Race - Ameri Black, White,	
21215-0036	I within 72 hou iene. r than "nature the Medical E	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		(Give kind life. DO l	s Usual Occupation of work done during m NOT use retired)	ost of working		nd of Business/Ir	ndustry NDUSTRY
Maryland 2	s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 Is marked other than other treumatic event, the M	To Be C	17. Father's Name (First, Middle, Last SOHN HAZZA 19a. Informant's Name/Relationship (	RD LARMOR	2E	18. Mo	ther's Name (First, N	Middle, Maiden	Sumame)	
-	1 and 2 Health tem 27		20a. Method of Disposition  1 ABurial 2 Cremation 3	N HUSBAND	Place of Disposition temperators	ddress (Street and Nurr Name of ry or other place)	Date	MTICC	cation - City or To	121840
Baltimore	permit. Pages Department of Importent: If ii any injury or once.		4 Donation 5 Other (Specification of Funeral Service Licer	n . 101	RNERS 22/Na	CEMETERY The and Address of Face TESSICIENT	10-18-05	-	#TICONE E PO	- Sheet -
	Physician /Medical		23a. Part1. Emer the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	t Overla	e mode of dying, such a		cory arrest,		Approximate Interval Between Onset and Death
8760,	certificate be executed to the following physician and the burial-transit to the certification and the certifi	ical Examiner	Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence)  Due to (or as a consequence)						
P.O. Box 68	certific Iding passes as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 💢 Vo 9 ☐ Unknown	23c. If yes, outcome of pregna _1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3 Ect	opic pregnancy er (specify)			3d. Date of delive	ery Day Year
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Division of Vital Records,	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page.	2	examiner?  1 Yes 2 No  27. Manner of Death  1 Novatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	0.5	Nursing Home 5 28d. Desc	Company of the last		y)
Divis	vitel or Atteurs after des vel Directo	Certification:	3 Suicide 6 Could not b 4 Homicide determined	building, etc. (Specify	()		City	or Town, State)	d Number or Rura	
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}	To T	Σ	29b. Signature and title of certifier	> Kan w	0.	29c. License number 29c. License number			signed (Month,	Day, Year)
	DM		30. Name and address of person who	completed cause of death (Item	23a) (Type, Print	MD 718	01/1	Dannil	P. Klin	MD
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		1		artment of Health and Men	tal Hygiene Reg. No	711115 3501E
	Physicia	an	Decedent's Name (First, Middle, Last)	N	ate of Death fonth Da	3. Time of Death 21, 2005 4:30A
	/Medic Examin		ERMON GOLDA CUSTIS  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
	Funeral	•	GENESIS LA PLATA CENTER  5. Social Security Number  6. Sex 7. Age (In yrs. last birthday)  1	Months Days Hours Min. (/	ate of Birth Wonth, Day, Year,	CHARLES  9. Birthplace (State or Foreign Country)
	Director	5	068-22-0561 Yrs. Usual Residence of Decedent	AU	GUST 19	),1914 N.C.
	Aaryland f show	or	10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	n the h	irect	1ARYLAND CHARLES LA PL 10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
	ath wit	ralD	1 MAGNOLIA DRIVE	20646	Yan or No	U.S.A.  14. Race - American Indian,
36	hours after death with the Maryland tural, or Itams 23a or 28a-f show al Exactine must be notified at	by Funeral Directo	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rical 1 ☐ Yes 2 ☑ No Specify:	n, etc.)	Black, White, etc.  Specify: WHITE
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Baltimore,	permit. Pag Department Important: I any injury o 2009.		21. Signature of Fuaeral Service Licensee M00479	22. Name and Address of Facility  RAYMOND FUNERAL	SERVICE	E, P.A.
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8760,	ate be executed hysician and he burial-transit		resulting in death) Last  Due to (or as a consequence of):  d.			
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0	uires that the de signed by the Id be detached	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?  2 No 3 Probably 4 Munknown
Records,	sician: The law requir s certificate has been si lirector, page 2 should I	Completed			24a. Was an autopsy performed?	
Vital	(0 ===	BeC	25. Was case referred to medical examiner?	26. Place of Death (Cl	heck only one)	
of	Jing Phy n. After this funeral d	2	1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat  27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	of 28c. Injury at 28d.	5 Residence Describe how inj	6 □Other (Specify) ury occurred
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28f.	Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)
	e Hospital 24 hours a a Funaral letely filled	edical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, de 2 Medicel Exeminer: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place, and investigation, in my opinion, death occurred a	due to the cause( it the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
	To the within 2 To tha complet	Me	29b. Signature and title of certifier	29c. License number	29d. C	Oate signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type	$ \begin{array}{cccccccccccccccccccccccccccccccccccc$		17485
	4		RICHARD J KELLY 170	164 FERRY DOCK	KIN	9 GEORGE VA
	St Regist	ate trar	31. Date filed (Month, Day, Year)  32. Paiskar's Signatura	Gode	- (	J

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) october iv **Physician** 2005 HELEN IRENE CHAIRES 4:10PM M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** RUXTON HEALTH OF DENTON CAROLINE DENTON 8. Date of Birth (Month, Day, Year OCT 17, 1 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 ☐ M 2 🙀 F 215-14-3609 84 Yrs. MARYLAND Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-1 show r then "naturel", or items 23a or 28a-f shorthe Medical Examiner must be recitived at Yes 2 □ No Completed by Funeral Director MD CAROLINE DENTON 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 420 COLONIAL DRIVE 21629 238 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2♠ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental H is marked of JAMES T. MULLIKIN . Pages 1 and 2 should be treent of Health and Menta tent: If item 27 is marked jury or other treumatic ev LILLIAN LARRIMORE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JOHN J. CHAIRES, JR./SON 32111 PARK AVE., QUEEN ANNE, MD 21657 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or WOODLAWN MEMORIAL PARK 10/14/2005 EASTON, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 MERCERON JOHN R. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 by Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) the Records, P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No 2 No 1 🗌 Yes 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Dursing Home 5 - Residence 6 - Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28h Time of 28d. Describe how injury occurred Certification: After To the Hospitel or Attending 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 10/12/05 ress of person who completed cause of death (Item 23a) (Type, Print) washington Steaston mo 2(60) 3€ Registrar's Signature State Registrar

**ORIGINAL** 

				1 - State State Registrar	of Maryland / Dep <i>Ce</i>	artment of He	ealth and M Death		iene	5	35048
		ę		Decedent's Name (First, Middle, Last)				2. Date of Deat	h		3. Time of Death
_		Physici /Modia		Mary Fefolt Campbell				October	12, 200	9ear	11:35 а м
	1	/Medic Examin		4a. Fecility Name (If not institution, give street and n	umber)	4b. City, Town, or L	ocation of Death		4c. County o	f Death	
	1			Suburban Hospital		Bethes	sda		Mont	gome	rv
		Funeral	1545	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday,			8. Date of Birth (Month, Day, June II		9. Birthpla	ce (State or Foreign
		Director		172-14-3088 ¹□M 28☐F	94 Yrs.	Wortens Days	110013	June II	, 1911	Penn	sylvania
		pu *		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation				100	d. Inside City Limits
		show	5		Beth					100	1 ☐ Yes 2 ☑ No
		the M	ect	Maryland Montgomery  10e. Street and Number	Decii	10f. Zip Code		11	Og. Citizen of Wi	ant Countr	
		filed within 72 hours after death with the Maryland Hygiene. vither than "natural", or items 23a or 28a-f show ent, the Madical Examiner must be notified at	Funeral Director	10250 Westlake Drive, A	ot. 717	20817	7	"	-	JSA	y :
		ne 23	era	11. Marital Status 12. Was De	cedent Ever in U.S. 13.	Was Decedent of His	panic Origin? (Spe	cify Yes or No-	14. Race	- Americar	n Indian.
	(0	or iter	臣	1 Never Married 2 Marned 1 Yes	orces?	If Yes, specify Cuban	, Mexican, Puerto	Rican, etc.)		, White, et	
	8	ai'.o	Ď	3 ☐ Widowed 4 ဩ Divorced If Yes, G Year or		1 ☐ Yes 2 反 No	Specify:		Specify:	White	е
	50	72 ho	Completed by	15. Decedent's Education (Specify only highest grade completed	16a. Dece	dent's Usual Occupat kind of work done du	tion	20	16b. Kind of Bus	iness/Indu	stry
	2	d within giene.	aldu	Elementary/Secondary (0-12) College	(1-4or 5+) life.	DO NOT use retired)	ining most of works	<i>'</i> 9			
	2	Hygier Hygier ther th	ပ္ပ	12	CI	erk					ernment
	힡	be fited ital Hyg od other	Be	17. Father's Name (First, Middle, Last)  Joseph Fefolt		1	18. Mother's Name Johanna		faiden Sumame	)	
	Ĕ	d Mer nark	2	19a. Informant's Name/Relationship (Type, Print)	106 14-15				0 T		
	Maryland 21215-0036	d 2 sl th an th an traur		Robert Keffer/ Nephew		ng Address <i>(Street an</i> Greencast					
	စ်	1 an Heat Tem 2		20a. Method of Disposition	20b. Place of Dispo	osition (Name of			20c. Location - C		
	Baltimore,	Solution of the second		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)		matory or other place, can Crematory	7   0000	er 13			
	量	nit. Fartme		21. Signature of Funeral Service License	11/1 8	Name and Address	200				Virginia
	ä	permit. Pages 1 and 2 should be fite Department of Health and Mental Hy Important: If item 27 is marked oth any injury peopler traumatic event once.		Mian (See		00 Univers					MD 20901
				23a. Part1. Enter the disease, or complications that	caused the death. Do not en	ter the mode of dying,	such as cardiac o	r respiratory arre	st,	A	Approximate
		Physician	X X	shock, or heart failure. List only one cause on Immediate Cause (Final						Č	nterval Between Onset and Death
		/Medical		resulting in death)	liopulmonary A o (or as a consequence of):	rrest					
_		Examiner		h Acut	e Myocardial	Infarction	ı				
Am		n =	ner		o or as a consequence of:						
10		and and Il-trans	Examiner	that initiated events c. Active	erosclerotic C	ardiovascu	ılar Dise	ase			
4	80,	be executed icien and burial-transit		Due to	o (or as a consequence of):						
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	9 xo	ocertification of use as	/Me	IF FEMALE:	utcome of pregnancy						
05	Bo	eath certif attending for use as	lan	in the past 12 months?	birth 2 Fetal death 3	Ectopic pregnancy			23d. Date Mont		ay Year
7	Ö	that the de ed by the detached	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unk		Other (specify)					
50/21/01	ص ّ	that the	by Physician/Me	Part II. Other significant conditions contributing to	death but not resulting in the u	nderlying cause given	in Part I.	23e. Did tob	acco use contrib	ute to the	cause of death?
0	rds	v requires been sign should be	q p	Atrial Fibrillation, Hy	pothyroidism,	Comfort (	Care,	1 ☐ Ye	s 2 🖾 No 3	☐ Probab	ily 4 □Unknown
	Records,		Completed	Ischemia of Left Lower	Limb. Ambulat	orv Dysfur	nction.	24a. Was an	24b. We	ere autops	v findings available
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2	Vital	ician: certifica rector, p	Bec	Malnutrition 25. Was case referred to medical			26. Place of Death	(Check only one		Yes 2	LI No
8	$\leq$	Physician: this certific ral director,	O B	examiner? 1 ☐ Yes 2 ☐ KNo Hospital: 1 ☐	Inpatient 2 ER/Outpatien		4 □ Nursing Hon			(Specify)	
Gampbel	0	tending Physician: The leath. tor: After this certificate ha the funeral director, page	Ľ.	27. Manner of Death 28a. Date	e of Injury 28b. Time onth, Day Year) Injury			8d. Describe how			
3	Ö	auth. or: After ne funer	atlo	2 Accident investigation	injury		s 2 □No				
>	Division	r Atta	Certification; To	3 Suicide 6 Could not be determined 28e. Plac	e of Injury - At home, farm, stiding, etc. (Specify)	eet, factory, office	2	8f. Location (Streetly or Town,	eet and Number State)	or Rural F	Route Number,
Mary		itel o									
3		Hosp 4 hou Fune Fune	Cal	29a. Certifier 1 Certifying Physicien: To the (Check only and contained on the contained on the certifier of the certifier on the certifier on the certifier of the certifier of the certifier on the certifier of	basis of examination and/or in	h occurred at the time vestigation, in my opir	, date and place, a nion, death occurre	nd due to the car	use(s) and mann te and place, an	ner as state	ed. le cause(s)
		To the Hospitel or Attant within 24 hours efter death To the Funeral Director: completely filled in by the	Medical	one) and ma  29b. Signature and title of certifier	nner stated.	29c. License					
		N N N		MAINA A	and an	29c. License 1			d. Date signed ( October		
		4			V 4000 ,						
				30. Name and address of person who completed car Shyamsundar Rajan, M.D.	ise of death (Item 23a) (Type, . 10810 Darnes	town Road,	, Suite 2	02, Gait	thersbur	g, M	d 20878
	1	Sta	te	31. Date filed (Month, Day, Year)	Registrar's Signature	N. B	, <u>.</u>				
		Registr		OCT 1 4 2005	Registrar's Signature	NEL!					

G			1 - For Unpend Item	State of 23a-b&27	Marylar per 1	nd / Departue G849	artmer	to-05 te of L	ealth an tas Death	nd Mental F	lygien Reg. N	2005	35049
· di		5.	1. Decedent's Name (First, Middle, L.							2. Date of	Death		3. Time of Death
	Physici /Medi		Jorge J	esus Diez	Canso	eco				Octob	er 12	2, 2005	11:30 A M
	Examir	- 4	4a. Facility Name (If not institution, gi		,				Location of E	Death	4	c. County of Death	
			Prince George's I				1	never				cince Geo	orge 's
70	Funeral		5. Social Security Number 6. 213-29-4971	Sex 7 1 ☑ M 2 ☐ F		last birthday) Yrs.	Months	r 1 Year Days	If Under 24 Hours		Birth <i>Day, Yeal</i>	r) 9. Birth	nplace (State or Foreign untry)
٥	> Director		Usual Residence of Decedent		62	110.				July 1	3, 1	943	Peru
	yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
	r 28a-f show	to	D.C.	I/A		W	ashir	ngton	, D.C.				1⊠Yes 2□No
	or 284	Director	10e. Street and Number					p Code	,		10g. C	itizen of What Cou	untry?
	death with the Maryland ims 23a or 28a-f show ir must be notified at	ai	822 Kennedy Stre	eet NW.				2	0011			Peru	
		Funerai	11. Marital Status	12. Was Deced Armed Ford	ent Ever in U	J.S. 13.	Was Dece f Yes, spe	dent of His	spanic Origin n, Mexican, P	? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Amer Black, White	
36	hours after tural', or ite	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 If Yes, Give						Peruvian		Specify: Hi	
21215-0036	hours tural',		3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E	Year or Dat	es:	16a. Dece							•
7	"na	Completed	(Specify only highest gi	ade completed)		(Give	kind of wo		urina most of	f working	160.1	Kind of Business/l	ndustry
212	d withir piene. r than	шо	Elementary/Secondary (0-12)	College (1-	tor 5+)				n Work	rer		Congta	ruction
p	Hyg otha	Φ	17. Father's Name (First, Middle, Las	1)		1				Name (First, Midd	lle, Maide		euction
a	0 0 0	ToB	Oscar Diez Can	seco					E1:	iana Cac	eres		
Maryland	s 1 and 2 should be f Health and Mental item 27 is marked other traumatic ev		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	s (Street a	n <i>d Number</i> o	or Rural Route Nur	nber, City	or Town, State, Zi	ip Code)
	5 = 2 E		Maria Fasce/Si	ster		3610	Coll	ier E	Rd., Be	eltsville	, MD	. 20705	
Baltimore,	es 1 av of Hea fitem r othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [	Domes of from C		Place of Dispo	sition (Na	me of other place	)	Date	20c. L	ocation - City or T	own, State
Ĕ	Pag nent ant: i		4 □ Donation 5 □ Other (Speci			te of 1	Heave	n Cer	n. Oc	t, 22, 20	005	Silver S	oring
alt	permit. Departr importi any inji		21. Signature of Funeral Service Lice	nsee An	100	1 22	. Name a	nd Address	of Facility	Pope Fur	craf	Homes	
_	20 E 2 9		· Cloa	7/1/4	reli	113	315 L	ockw	pood D	Rive, S	Ver	Spring,	WH 20904
п			23a. Part1. Enter the disease of conshock, or heart failed. List only	plication that can one cause on ear	used the deat th line.	th. Do not ent	er the mod	de of dying	, such as car	rdiac or respiratory	arrest,	, ,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Intrac	rania]	l Hemor	rhage	e					Onset and Death
	/Medical Examiner		resulting in death)		as a conseq			<del>-</del>					
i de	LAGITITIE	_	Sequentially list conditions,	b. Hypert			ovas	cular	Disea	se			
	pe is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseq	uence of):							
	be executed ician and burial-transit	хап	that initiated events resulting in death) Last	C	as a conseq	mence of):							
8760	cate be execu physician and the burial-tra			200 (0)	40 4 0011000	aonos on.							
687	physics the Is	dical		d									
	leath certific attending p I for use as	Physiclan/Me	IF FEMALE:	23c. If yes, outco	me of pregna	ancv						004 Date of date	
Box	atter I for u	clar	23b. Was decedent pregnant in the past 12 months?	1☐Live birt	h 2 ∐Feta ntattime of d	ıl death 3 □	Ectopic p	regnancy				23d. Date of deliv Month	ery Day Year
P.O.	y the	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐Unknow			0.000 (0)	, , , , , , , , , , , , , , , , , , ,					
	equires that sen signed b rould be deta		Part II. Other significant conditions	contributing to dea	th but not res	ulting in the ur	nderlying o	ause give	n in Part I.	23e. Die	tobacco	use contribute to t	the cause of death?
Records,	quires n sign	Completed by								10	Yes 2	. □No 3 □ Prol	bably 4 Unknown
Ö	- 5-	lete								24a. W	ıs an	24h Were auto	opsy findings available
Be	sician: The law certificate has t irector, page 2 s	E								au	opsy formed?	prior to co	empletion of cause of
Vital	ifficat or, p	a	25. Was case referred to medical						00 Dia41	1/2 Yes		1 (Yes	2 □ No
>	Physician: this certific ral director,	ToB	examiner? N☐ Yes 2☐ No	Hospital:	vationt 2	ER/Outpatien	3 □ DC	Othor		Death (Chéck onl		6 ☐Other (Special	
0	g Phya er this eral di	盲	27. Manner of Death	28a. Date of	Injury	28b. Time of		28c. Injury Work		28d. Describ			ry)
io	nding ath. r: After e funer	age	1 Anatural 5 Pending 2 Accident investigation		Day Year)	Injury	М		es 2 No				
Division of	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	3 Suicide 6 Could not be determined	289. Place o	Injury - At he	ome, farm, stre	eet, factory	y, office		28f. Location	(Street ar	nd Number or Rura	al Route Number,
Ö	s afte ai Dir	Ser	4 Homeso	Dusiding	, etc. (Specif	у)				City or 1	own, State	9)	
	To the Hospital within 24 hours a To the Funeral completely filled		29a. Certifier 1 Certifying Pl	nysician: To the b	est of my kno	wledge, death	occurred	at the time	, date and pl	lace, and due to th	e cause(s	) and manner as s	stated.
	he H in 24 he Fi	Medicai	one)	miner: On the bas and manne	s of examina r stated.	ition and/or inv	estigation	, in my opi	nion, death o	occurred at the time	e, date an	d place, and due to	o the cause(s)
	To T com	Σ	29b. Signature and title of certifier	1	1		290	c. License				ite signed (Month,	
			- Carol H	allan	rud			OCM			OCCOL	per 13, 2	COOL
0			30. Name and address of person who	completed cause	of death fiten	n 23a) (Type, I	Print) 11	ll Pe	nn Str	eet Bal	timor	e. Marvl	and 21201
1			CARCUL HI	120110	ma								
	Sta Registr		31. Date filed (Month, Day, Year)  OCT 2 5 200	Reg	istrar's Signa	iture do	A.						
		11	UL 1 & 3 ZU	J V /	US A	15,1	-						

	1	For State Registrar	State of Maryl		tificate of		, ,	g. No.2 0 0 5	35050
Physiciar		1. Decedent's Name (First, Middle, Last)  JOSEPH ALEXANI	DIAGU	ENIKO			2. Date of Death Month	Day Year	3. Time of Death
/Medica	1	JOSEPH ALEXANI  4a. Facility Name (If not institution, give s		IENKO	4b. City. Town	or Location of Deat	OCT	25, 2005 4c. County of Deal	4:45 A M
Examine		CIVISTA MEDICAL C			LAPL			CHARLE	
uneral		5. Social Security Number 6. Sex	M 2 F	vrs. last birthday)	If Under 1 Year Months Days		(Month, Day,	Year) 9. Birt	thplace (State or Foreign buntry)
rector	1.	100-28-5069 '5 Usual Residence of Decedent	7	O Yrs.			FEB.28	,1935  NE	W YORK
how		10a. State 10b. County		City, Town or Lo					10d. Inside City Limits
culfie	600	MARYLAND CHARLI	55	LA PLA			10	- China at Milat C	1 ☐ Yes 2 ☒ No
d other than "natural", or Itama 23a or 28a-f show event, the Medical Examiner must be notified at	≒⊢	10e. Street and Number 9217 MIMOSA DRIV	/E		10f. Zip Code	6	10	g. Citizen of What Co U . S . I	
ms 23	era		I2. Was Decedent Ever i	n U.S. 13. y			Specify Yes or No-	14. Race - Ame	encan Indian,
or its		1 Never Married 2 Married	Armed Forces?  1X Yes 2 No If Yes, Give Year or Dates: 195	1			to rycan, etc.)	Black, Whit	
al Ex	ed Dy	3 ☐ Widowed 4 ☐ Divorced		- 1	ent's Usual Occu			6b. Kind of Business/	HITE
Medic	Completed	(Specify only highest grade		(Give	kind of work done OO NOT use retire	during most of wa	deina		RFACE WAR-
T T	Sol	12	5+	RESE	ARCH PS	YCHOLOG	ITOI	FARE CEN	rer
ed off	ň	17. Father's Name (First, Middle, Last)  ALEXANDER DIAC	THENKO				me <i>(First, Middle, N</i> PANCURA)		
tem 27 is marked other traumatic ev	0	19a. Informant's Name/Relationship (Ty		19b. Mailin	g Address (Street			City or Town, State, 2	Zip Code)
27 ls er trau	J	SANDRA DIACHENI	O-WIFE	921	7 MIMOS	A DR.,	LA PLAT	A, MD 20	0646
If Item 27 I		20a. Method of Disposition 1 □ Burial 2 ☑ ☆remation 3 □ R		<ul> <li>b. Place of Disposemetery, cren</li> </ul>	sition (Name of natory or other pla	ce)	Date 2	0c. Location - City or	Town, State
tant:		4 Donation 5 Other (Specify)	METRO	- mari			0-27-05	ALEXANDE	RIA, VA
Important: If Its any injury or o once.		21. Signature of Funeral Service License	M0047		Name and Addre	FUNERA	L SERVI		
		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the c	leath. Do not ente	A PLAT er the mode of dyi	A, MARY ng, such as cardia	LAND 204 c or respiratory arre	546 st,	Approximate Interval Between
sician		Immediate Cause (Final disease or condition	o saass on saan mis.	SE	VERE	SEI	2515		Onset and Death
dical niner		resulting in death)	Due to (or as a con	sequence of):	DACITI	/ B	DITTE	- M. A	
. 30	- G	Sequentially list conditions, if any, leading to immediate	Due to (or as a con	sequence of):	031110	ED	ACTER	EMIN	
transit	amine	cause. Enter Underlying Cause (Disease or injury that initiated events		ELLU	1417	15			
rial-	ŭ	resulting in death) Last	Due to (or as a con	sequence of):					
the attending physician a hed for use as the burial-	gica								
158 35	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pre					23d. Date of del	iverv
ad for	ICIa	in the past 12 months? 1  Yes 2 No	1 Live birth 2 ☐ F 4 Pregnant at time 9 Unknown		Ectopic pregnanc Other (specify) _	y		Month	Day Year
etach	<u>ج</u>	9 Unknown		sasultina in the co		one in Cont.	22a Diduah	acco use contribute to	the course of decade?
igne bed	2	Part II. Other significant conditions con	FL FA	1)_UR	oderiying cause gr	ven in Part I.		acco use contribute to s 2 □ No 3 □ Pr	
shoul	Completed	1150	271715	100/1			24a. Was an		itopsy findings available
	d l	TET	F 113				autopsy perform	ed? prior to death?	completion of cause of
age 2	ے ت	25. Was case referred to medical examiner?				26. Place of De	1 ☐ Yes 2 ath (Check only one	ZNo 1 ☐ Yes	2 No
ctor, page 2	ge G		ospital:	2 ER/Outpatien	3LI DOA			nce 6 Other (Spe	cify)
this certificate has	0 12	1 ☐ Yes 2 No	1 € Inpatient			rv at	28d. Describe how	v injury occurred	
ther this certificate has ineral director, page 2	0 0	1 ☐ Yes 2 ☐ No ☐ F 27. Manner of Death 1 ☐ Natural 5 ☐ Pending	1 Inpatient 28a. Date of Injury (Month, Day Yea	r) 28b. Time of Injury	28c. Inju Wo				
iffer this certificate has ineral director, page 2	0 0	1 Yes 2 No Pending 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Yea	At home, farm, stre	M 1	rk? ]Yes 2 □No	28f. Location (Str.	eet and Number or Ru	ıral Route Number,
iffer this certificate has ineral director, page 2	0 0	1 Yes 2 No Pending 27. Mannar of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	At home, farm, stre	M 1				ural Route Number,
ifter this certificate has ineral director, page 2	Certification: Io B	27. Mannay of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only) 27. No  Pending investigation 6 Could not be determined	28a. Date of Injury -/ (Month, Day Yea  28e. Place of Injury -/ building, etc. (Sp	At home, farm, streecify)	M 1 =	Yes 2 □ No	28f. Location (Str. City or Town,	State) use(s) and manner as	stated.
he Funeral Director: Atter this certificate has pletely filled in by the funeral director, page 2	90	27. Manner of Death  1	28a. Date of Injury (Month, Day Yea 28e. Place of Injury - building, etc. (Sp	At home, farm, streecify)	M 1 =	Yes 2 No	28f. Location (Str. City or Town, e, and due to the ca urred at the time, da	State) use(s) and manner as	stated. to the cause(s)

State Registrar

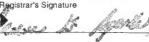
DHMH 17 Rev 1/2001

9+1

ABBAS A. OMAIS MD 7-C POST OFFICE RD. WALDORF, MD 20602

31. Date filed (Month, Day, Year)

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 4b c per doc 9850 12-22-05 vt.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			1 - For State Registrar			, (	Ce		ate of	Death	o morna	Reg.		5	35051	
3.5	Dhueiei	dn E	1. Decedent's Name (First, M			2					2. Date Mon	of Death		/ear	3. Time of Death	_
	Physici /Medic				MAL	DUG	AR					10		.005	1545 PM	
7	Examin	er	4a. Facility Name (If not instit	-		1.1			ty, Town, o	r Location of De	eath		4c. County of Monta		rv	
			5. Social Security Number	ROVE 6. Se			ast birthday		der 1 Year	If Under 24 F	rs. 8 Date	of Birth			ace (State or Foreign	_
*	Funeral Director		054-48-5139 Usual Residence of Deceden	1	XM 2□F	67	Yrs.	Month			lin. (Mon	of Birth th, Day, Ye	938	Ind	ry)	
	land ow		10a. State 10b. Con			10c. City	, Town or L	ocation.						10	d. Inside City Limits	-
	Many B-f•h	ţċ	MD Mon	tgom	nery	Ge	ermar	ıtow	n					ļ	1 ☐ Yes 2 🖾 No	
	with the 3s or 28s	I Direc	10e. Street and Number 12231 Ston	ey E	ottom Ro	oad		1 Of.	Zip Code 20	874		10g.	Citizen of Wh		ry?	
920	be filed within 72 hours after death with the Maryland ital Hygiene. A other than "natural", or items 23s or 28s-f ehow event, the Medical Examinat must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 3 Widowed 4 Divor		12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:		S. 13.		cedent of H becify Cuba 2 No	ispanic Origin? an, Mexican, Pu Specify:	(Specify Yes Jerto Rican, et	or No-	14. Race - Black, Specify:	White, e		
21215-0036	72 ho	Completed	15. Dece (Specify only hi	dent's Ed	ucation de completed)		16a. Dece	edent's U	sual Occup	ation	working	166	. Kind of Busi	ness/Ind	ustry	_
121	- 1	mpje	Elementary/Secondary (0-1	-	College (1-4or 5	5+)				during most of (						
	filed v Hygie other t		17. Father's Name (First, Mid	dle. Last)	5+_		Dire	ecto	r of				V. U.S		reasury	_
an	d be antal ked o c eve	To Be	Man Mal Du										r Meht			
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Market	F	19a. Informant's Name/Relat	onship (7	ype, Print)		19b. Mail	ing Addre	ss (Street	and Number or	Rural Route I	Vumber, Ci	ity or Town, St	ate, Zip	Code)	
	alth 27		Pushpi Duga	r/Wi	fe		122	231	Ston	ey Bot	tom R	d. G	ermant	towr	,Md20874	4
Baltimore,	Pages 1: ent of He mt; If Itan	1 Burial 2 Socremation 3 Removal from State Riverdale Park 10 Donation 5 Other (Specify)								:e)	Date / 16/0		iverda			
Balti	permit. Depertm Importa any inju		21. Signature of Juneral Sen		11	- (	É	HIL	I PAddre	ss of Each AL	DI FU	NERA.	L SERV	/ICE	E,P.A.	_
· .	2		23a. Part1. Enter the disease	, or comp	lications that caused	the death.		241 iter the m	ode of dyin	ullID1a g, such as card	BIVQ.	SIIV tory arrest,	er spi		Md20910	<u>)</u>
ı	Physician		shock, or heart fallure. Immediate Cause (Final disease or condition	List only o			HACK								Interval Between Onset and Death	
3	/Medical		resulting in death)		Due to (or as									4	-weeks	_
*	Examiner		Sequentially list conditions.		b. ASPIR			LUMI	NIA					1	3 weeks	
	be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	~	Due to (or as				_					- 1	2	
	be executed sician and burial-transit	хап	that initiated events resulting in death) Last	1	c. LSCHE Due to (or as			16,~	OPA	TH Y					2 years	
68760,	sician buria			-												
	artificate t ing physi e as the b	Medical			d					-						
.O. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	⊒Ectopic ⊒ Other	pregnancy (specify)				23d. Date of Month		y Day Year	
<u>α</u>	that the ed by detac	/Ph	Part II. Other significant con	ditions co	entributing to death b	ut not resul	Iting in the t	underlying	cause give	en in Part I.	23e.	Did tobaco	co use contribu	ute to the	cause of death?	-
rds	quires in sign uld be	ed by										1 🗌 Yes	2 No 3	☐ Proba	bly 4 □Unknown	
Vital Records,	The taw requirate has been spage 2 should	Completed									-	Was an autopsy performed	?/ dea	or to com th?	sy findings available pletion of cause of	
ta	an: 1 tifical tor, p	0	25. Was case referred to mee	tical		-717/10/10/				26. Place of F	1□ 1 Death   Check		No 1L	Yes 2	₽ŒNo	
of V	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No		Hospital: 1 🖃 Inpatie	nt 2 🗆 E	ER/Outpatie	nt 3[]	DOA Othe	ori			6 □Other	(Specify)		
o uo			27. Manner of Death  1 Natural 5 Pe 2 Accident	nding estigation	28a. Date of Inju (Month, Da	y Year)	28b. Time o Injury	of M	28c. Injury Work 1 🔲	/ at ⟨? Yes 2 □ No	28d. Des	cribe how in	njury occurred			_
Division	al or Attending s after deeth. Il Director: After id in by the fune	Certification:	3 ☐ Suicide 6 ☐ Co	uld not be ermined	28e. Place of Injubulding, etc.	ury - At hor c. (Specify)	ne, farm, st	reet, fact	ory, office		28f. Loca City	tion (Street or Town, St	t and Number tate)	or Rurai	Route Number,	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical (	29a. Certifier 1 Cert. (Check only one) 1 Medi	fying Phy cal Exam	rsician: To the best iner: On the basis of and manner sta	examinati	vledge, dea on and/or in	th occurre	ed at the timon, in my op	ne, date and pla pinion, death oc	ace, and due t ocurred at the	o the cause time, date	e(s) and mann and place, and	er as sta d due to t	ted. he cause(s)	_
	To the within 2 To the complet	ž	29b. Signature and Title of cer	tifier	21,			2	9c. License				Date signed (			-
(1	3)3		Teles	/ //	Ut 1	D			DO	0584	15	0	ttosc	15	2005	
-			30. Name and address of per	son who c	ompleted cause of d		23a) (Type		lical	0584; Drive	Ga	.thess	on Mr	) 2	0810	
4 14 14	Sta	te	31. Date filed (Month, Day, Y	7 21	32 Registra	ar's Signati	ure	BALL.	,				)/			

			State of Sta	of Maryland / Dep 28a-f per me				Reg. No.	35053
· 3	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of De Month	Day	3. Time of Death
	/Medi		DAVID AMOS	DeLAWDER			OCTOBE	R 21, 20	005 9:11 P <sup>M</sup>
20	Examir	er	4a. Facility Name (If not institution, give street and nu	mber)		or Location of Death		4c. County	
2		35.	SHADY GROVE HOSPITAL			ERSBURG			GOMERY CO
70	Funeral Director		5. Social Security Number  226-15-3617  Usual Residence of Decedent	7. Age (In yrs. last birthday, 42 Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da Mar •	1963	9. Birthplace (State or Foreign Wash, DC
	and w		10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
	n the Maryland r 28a-f show unotified at	ō	MD Montgomery	Gaithe	rshura				Yes 2 No
	28a	Director	10e. Street and Number	darene	10f. Zip Code			10g. Citizen of V	What Country?
	23a or	O	18533 Boysenberry	or #285	208	79		U.S	S.A.
9	hours after death with the Maryland ural', or tleme 23a or 28a-f show al Examinar must be notified at	/ Funerai	11. Marital Status  12. Was Dec Armed Fr 1 ☑ Never Married 2 ☐ Married  1 ☐ Yes 1 ☐ Yes 1 ☐ Yes	edenl Ever in U.S. 13. orces?	Was Decedent of If Yes, specify Cub	Hispanic Origin? (Spi ban, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Rac Blac	e - American Indian, ck, White, etc.
003	ural',	d by	3 ☐ Widowed 4 ☐ Divorced Year or E	Dates:					7:111.00
215-	within 72 h ene. than "nati	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (	1-4or 5+) (Give		e during most of work ed)		16b. Kind of B	usiness/Industry
12	77 To be 450		9th	Pri	nting/	Carpentr			
Maryland 21215-0036	should be filed and Mental Hyg marked othe amatic event,	To Be	17. Father's Name (First, Middle, Last)  Roy Chester DeLaw			18. Mother's Name	ne Wi	right	
, Mar	and 2 sh eaith and n 27 is m		19a. Informant's Name/Relationship (Type, Print) Harley A. DeLawder-						State, Zip Code) 1, VA 22202
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Monta Important: If item 27 is marked any injury or other traumatic events.		20a. Method of Disposition  1 ☐ Burial 2 ② Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State   20b. Place of Disponentery, cre   Metro F	matory or other pla	ace)	25/05		City or Town, State adria, VA
Balt	permit. Departimonts Imports any inj	ے	21. Signature of Funeral Service Licensee  23a. Part1. Enter the rise ise, or complications that shock, or heart failure. List only one cause on	900ll 12	46 N. W	<i>l</i> ashingto	n St 1	Rockvil	Home, P.A. Lle, MD 2085
1760,	Physician /Medical Examiner up prival-itansii	icai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  a Narcot  Due to	(or as a consequence of):  (or as a consequence of):					Interval Between Onset and Death
P.O. Box 68	The law requires that the death certificate to the laws been signed by the attending physicage 2 should be detached for use as the toate.	Physician/Med	in the past 12 months?	nant at time of death 5[	⊒Ectopic pregnanc ⊒ Other (specify) _	ду		23d. Dai	e of delivery nth Day Year
	w requires that been signed bi should be deta	ē	Part II. Other significant conditions contributing to d	eath but not resulting in the u	nderlying cause g	iven in Part I.	23e. Did to	. /	ribute to the cause of death?  3 Probably 4 Unknown
Reco	The law re ate has bee page 2 sho	Completed						rmed?	Were autopsy findings available prior to completion of cause of death
ita	sician: certifica rector, p	BeC	25. Was case referred to medical examiner?			26. Place of Death			
>	S S D	To		Inpatient 2000/Outpatie	nt 3 DOA	her: 4 Nursing Ho	me 5 Resid	dence 6 □Oth	er (Specify)
Division of Vital Records,	a fie	Certification:	2 Accident investigation 10-21	In Day Year) Found 8:31	P M	Yes 2 No		now injury occurr	unk
Divi	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		4 Homicide determined build Four	e of Injury - At home, farm, st ing, etc. (Specify) at home		]	Or. Gai	thersbur	
	ne Hosi n 24 ho ne Fune letely fi	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the bandical Examinar: On the band man	e best of my knowledge, deat easis of examination and/or in oner stated.	h occurred at the t vestigation, in my	ime, date and place, a opinion, death occurr	and due to the ed at the time,	cause(s) and ma date and place, a	nner as stated. and due to the cause(s)
	To the within To the Comp	ž	29b. Signature and title of certifier	1.		se number		29d. Date signed	(Month, Day, Year)
			May all The C	Kull M12	OCI	YLE		OCTOBER	22, 2005
			30. Name and address of person who completed cau	se of death (Item 23a) (Type,	Print) 111 I	Penn Stree	t Balt		Maryland 21201

State Registrar MARY DUTA
31. Date filed (Month, Day, Year)

OCT 2 6 2005

KORTU
32 Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

ORIGINAL

32. Presstrar's Signature

2005

		-	For	epartment of Health and N Certificate of Death	lental Hygiei	ne <b>2.</b> 005	35055		
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Dorothy May DeGra	nge	2. Date of Death Month October		3. Time of Death 11:10 P M		
	/Medic Examin	or	4a. Facility Name (If not institution, give street and number) Beverly Healthcare	4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick			
	Funeral Director		5. Social Security Number 6. Sex $1 \square M$ $2 \square F$ 7. Age (In yrs. last birth $217-03-5562$ $92$ Y	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye March 22,	9. Birthpl Coun 1913 Man	ace (State or Foreign try) ryland		
99	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or iteme 23a or 28e-1 show eny figury or other treumetic event, It a Medical Examinat must be rollified at once.	Funeral Director	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town  Maryland Frederick  Frederi  10e. Street and Number  30 North Place  11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?  1			Citizen of What Coun  U.S.A.  14. Race - Americ Black, White, (	an Indian, etc.		
21215-0036	ad within 72 hours vgiene. er than "neturel", i, ire M. dical Exal.	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 7    College (1-4or 5+)	Decedent's Usual Occupation Give kind of work done during most of work life. DO NOT use retired)  Cook	ing	Kind of Business/Inc			
and	ild be file lental Hy ked oth ic event	Be				den Sumame)			
Mary	d 2 shou th and M 17 is mar treumet	-	112.1	•		-			
Baltimore, Maryland	Pages 1 an ient of Heal nt: If item 2 iry or other		1 X Burial 2 Cremation 3 Removal from State	, crematory or other place)	No.	ederick, Ma			
Balti	permit. Departm Importa eny inju		21. Signature of Junior S. M. Coensee	RÔBERT E. DAILEY & S 1201 NORTH MARKET ST	SON FUNERA	AL HOMES, I RICK, MD 21	P.A. 1701		
8760,	cate be executed /Medical Examiner street burial-transit	23a. Part. Sater the disease, or complications that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):							
.O. Box 68	ne death certifi the attending thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ry Day Year		
<u>α</u>	quires that the signed by aid be detacted	by	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobace	co use contribute to the	e cause of death?		
I Records,	The law ate has b page 2 sl	Completed			24a. Was an autopsy performed	prior to cor death?	psy findings available inpletion of cause of 2 No		
Vital	Physicien: The this certificate al director, pag	o Be (	25. Was case referred to medical examiner?  1  Yes 2  Hospital: 1 Inpatient 2 ER/Out	Othor .	h (Check only one) me 5□ Residence	e 6 □Other (Specify	<i>(</i> )		
Division of	Sing I. After funer	Certification: T	27. Manner of Death 28a. Date of Injury 28b. Ti	me of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how i	injury occurred  at and Number or Rura			
_	Hospite 4 hours Funerel ely fillec	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, 2 Medical Exeminer: On the basis of examination and manner stated.	death occurred at the time, date and place, /or investigation, in my opinion, death occur	and due to the caus red at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)		
)	To the within 2 To the complet	Me	29b. Signature and title of certifier  M	29c. License number		Date signed (Month,			
	3		30. Name and address of person who completed cause of death (Item 23a) ( SAJJAD AZ (2, MO. 8c)	1 Tell House	Ave, F	rederiel	2005 MD2170		
	Sta Regist		31. Date filed (Month Cay, Year) 32 Magistrar's Signature	Sports					

State of Maryland / Department of Health and Mental Hygie [6] [5] 35056

		•	1 - State Registrar	Certi	ificate of L	Death	Re	g. No.			
			Decedent's Name (First, Middle, Last)			2	. Date of Death Month	Day	Year	3. Time of E	Death
	Physicia /Medic		Virginia	Day		0	ctober			6:45	$A^{M}$
	Examin		4a. Facility Name (If not institution, give street and number)	4	4b. City, Town, or	Location of Death		4c. Count	y of Death		
	4		National Lutheran Home		Rockvil			Mont	gomer		
Ь	Funeral Director		5. Social Security Number 271-14-4422 6. Sex 1 □ M 2X F 7. Age (In yrs. last 88		Months Days	Hours Min.	Date of Birth (Month, Day, 11y 31,		9. Birthp Coun Oh		Foreign
	D		Usual Residence of Decedent  10a. State 10b. County 10c. City,	Town or Loca	ation				1	0d. Inside City	v Limits
	aryla shov	5			2001					1 🗆 Yes	
	the M	ect	Maryland Montgomery Rock	ville	10f. Zip Code		10	g. Citizen of	What Cour	ntry?	
	with with	Funeral Director	9701 Veirs Drive		20850	)		U.S.A		,	
	ns 23	era	11 Marital Status 12, Was Decedent Ever in U.S.	. 13. W		ispanic Origin? (Speci In, Mexican, Puerto Ri	y Yes or No-	14. Ra	ce - Americ		
S	or iter	교	Armed Forces?  1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No			in, mexican, Puerto Ri Specify:	can, etc.)		ack, White,	etc.	
8	ral', c	by	3 ☐ Widowed 4 ☐ Divorced		⊒Yes 2X∏ No	эрөску.		Speci	Whi	te	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. dother then "natural", or items 23e or 28a-f show event. The Mudical Esta nicet must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decede (Give ki	nt's Usual Occupa	ation during most of working f)	. 1	6b. Kind of E	łusiness/Ind	dustry	
121	vithin ne. hen	mpi	Elementary/Secondary (0-12) College (1-4or 5+)		erical	7)		Cler	ical		
2	Hygie Hygie ther t		17. Father's Name (First, Middle, Last)			18. Mother's Name (	First, Middle, M				
an	2 should be filed within n and Mental Hygiene. I is marked other then reumatic event, I'le M	o Be	William Mitchell Day			Sara A.	Warden				
<u>F</u>	shoul mark matt	은	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street a	and Number or Rural I	Route Number,	City or Town	, State, Zip	Code)	
	nd 2:	100	Kristina Hughes (Executor)	9701 V	eirs Dr.	, Rockvill	Le, MD 2	20850			
re,	es 1 and 2 should b of Health and Ments fitem 27 is marked r other treumatic e		20a. Method of Disposition 20b. Pla	ace of Disposit	ition (Name of atory or other place	Dai	е 2	Oc. Location	- City or To	wn, State	
Baltimore,	permit. Pages Department of I Importent: If it any injury or o		1   Burial 2 X   Cremation 3     Hemoval from State			atory 10/17	7/05	Alexa	ndria	, VA	
alti	permit. Departm Importe any inju		21. Signature of Funeral Service Licensee		Name and Addres	ss of Facility					
<u> </u>	88 = 8	111	M. M. Organia	6	510 16+h	St. N.W.	Washing	gton,	DC 20		
			23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	Do not enter	r the mode of dyin	ng, such as cardiac or	espiratory arre	st,		Approximate Interval Betw Onset and D	ween
	Physician		Immediate Cause (Final disease or condition	i Se	-PSIS	•				7 day	5
	/Medical Examiner		resulting in death)  Due to (or as a conseque		1	/ (.				10 10.	
	Examine.	-	Sequentially list conditions,  Due to (or as a consequence)	ence of):	act 1	njection	n		/	Dan	73
	ted	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			J					
	icate be executed physician and s the burial-transit	Examiner	that initiated events c	ence of):							
68760,	e be sicia e bur		d								
	tificat ng ph) as th	Medical									
Вох	eath cert attending	_	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal of		Ectopic pregnancy	,			ate of delive		/ear
4	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician	in the past 12 months?  1  Yes 2 No 4 Pregnant at time of dea	ath 5□	Other (specify)				Ontri	Duy .	Cai
P.0	nat the de d by the a letached	Phy	Part II. Other significant conditions contributing to death but not result	lting in the un	deriving cause giv	en in Part I	23e. Did tob	acco use cor	ntribute to t	he cause of de	eath?
5,	ires that signed t	by	Alzheiners Dement	46	sorrying occuse giv	or are a		s 2 kNo		bably 4 □U	
Vital Records,	w require been sig should t	Completed by	The state of the s	-1			24a. Was an	24h	Were auto	ppsy findings a	availahle
36	has has	ם	Diabetes				autopsy	red?	prior to co death?	impletion of ca	ause of
a	ilcien: Th certificate rector, pag	e Co	25. Was case referred to medical			26. Place of Death (	1 Yes 2		1 🗆 Yes	2∐ No	
Ξ	sicie s certi irecto	m	examiner?  1 Yes 2 Hopital: 1 Inpatient 2 E		3□ DOA Oth				ther (Specif	fv)	
0	9 Physer this eral di	n: To	27. Manner of De th 28a. Date of Injury	28b. Time of Injury	28c. Injur Wor	yat 28	d. Describe ho				
io	ttending F death. ctor: After y the funera	atio	2 Accident investigation	injury		Yes 2 □ No					
Division of	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stree	et, factory, office	28	f. Location (Str City or Town		iber or Rura	al Route Numi	ber,
	urs al		29a. Certifier 1 Certifying Physician: To the best of my know	dodge deeth	annumed at the tir	mo data and place as	id due to the ca	ueo(e) and n	nanner as s	stated	
	Hos 24 ho Fun etely f	edical	29a. Certifier (Check only one) (Check only one) (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	on and/or inve	estigation, in my o	ppinion, death occurred	at the time, da	ite and place	, and due to	o the cause(s)	)
	Fo the	Me	29b. Signature and title of certifier		29c. Licens			d. Date sign			
	->-0		I I I smill m	0	000	50612	Ć	Octob	er 11	4,200	25
0	(1)		30. Name and address of person who completed cause of death (Item							Th.	
7	0		SAMUEL 6. MALLER ME			Dr., Rockv	ille, M	D 2085	0		9
	Sta Regist	ate	31. Date filed (Month, Day, Year)  OCT 1 7 2005	штө бора	W						
	negist	reir	OOI T I TOOL MANAGEMENT NO.	1							

Physician	
Physician Martin SAMIEL COOPER DAWSON, JR.  SAMISBURY REIAB & NURSING CENTER  SALISBURY NO. 21804  Financial  SALISBURY REIAB & NURSING CENTER  SALISBURY NO. 21804  Financial  SALISBURY NO. 21804  Financial  F	505/
ALISBURY REHAB & NORSING CENTER  SALISBURY, MIND 2 180  WICOMICO  TO 10 5 5000 Servity Number of Service of Programs of	. Time of Death
SALISBURY REHAB & NURSING CENTER    SALISBURY   SALISBURY   S. Social Security Numbers   S. Sex   7. Age flory is an abilimentary   S. Social Security Numbers   S. Sex   212-1-0-6337   Usual Residence of Decedent   100. Control   100. City, Town or Location   100. City, Town	*:00 A
Second Secretify Number   S. Sax   2.0   3.0	
Summer   Control   Contr	(Clata or Fornian
Doc Street and Number   100. Clay   100.	
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Physician Medical Examiner  Population of the physician of the	
Medical Examiner    Part   Par	proximate erval Between aset and Death
Second to the past 12 months?   23c. If yes, outcome of pregnancy   1   23b. Was decedent pregnant   23c. If yes, outcome of pregnancy   1   23b. Other (specify)   Month   Day   Month   Da	<i>71</i> →
9 Unknown	
9 Unknown	11112
25. Was case referred to medical examiner?  1	y Year
25. Was case referred to medical examiner?  1	
25. Was case referred to medical examiner?  1   Yes 2   No  28a. Date of Injury   28b. Time of Injury   28c. Injury at Work? 1   Yes 2   No  27. Manner of Death   1   Matural   5   Pending investigation   3   Suicide   4   Homicide   4   Hom	etion of cause of
Solution	
28a. Date of Injury  28b. Time of Injury  28c. Injury at Work?  28d. Describe how injury occurred  28d. Describe how inju	
2 A Accident 3 Suicide 4 Homicide 2 Se. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 Set. Location (Street and Number or Rural Row City or Town, State) 2 Set. Location (Street and Number or Rural Row City or Town, State) 2 Set. Location (Street and Number or Rural Row City or Town, State) 2 Set. Location (Street and Number or Rural Row City or Town, State) 2 Set. Location (Street and Number or Rural Row City or Town, State) 2 Set. Location (Street and Number or Rural Row City or Town, State) 2 Set. Location (Street and Number or Rural Row City or Town, State) 2 Set. Location (Street and Number or Rural Row City or Town, State) 2 Set. Location (Street and Number or Rural Row City or Town, State) 2 Set. Location (Street and Number or Rural Row City or Town, State) 2 Set. Location (Street and Number or Rural Row City or Town, State) 2 Set. Location (Street and Number or Rural Row City or Town, State) 2 Set. Location (Street and Number or Rural Row City or Town, State) 2 Set. Location (Street and Number or Rural Row City or Town, State) 2 Set. Location (Street and Number or Rural Row City or Town, State) 2 Set. Location (Street and Number or Rural Row City or Town, State) 2 Set. Location (Street and Number or Rural Row City or Town, State) 2 Set. Location (Street and Number or Rural Row City or Town, State) 2 Set. Location (Street and Number or Rural Row City or Town, State) 2 Set. Location (Street and Number or Rural Row City or Town, State) 3 Set. Location (Street and Number or Rural Row City or Town, State) 3 Set. Location (Street and Number or Rural Row City or Town, State) 3 Set. Location (Street and Number or Rural Row City or Town, State) 4 Set. Location (Street and Number or Rural Row City or Town, State) 4 Set. Location (Street and Number or Rural Row City or Town, State) 4 Set. Location (Street and Number or Rural Row City or Town, State) 4 Set. Location (Street and Number or Rural Row City or Town, State) 4 Set. Location (State and Number or Rural Row City or Town,	
29a. Certifier (Check only one)	oute Number,
100 C C C C C C C C C C C C C C C C C C	d. ∋ cause(s)
29c. License number 29d. Date signed (Month, Day,	, Year)
028388 10/18/08	B
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
WILLIAM ROBINS, M.D. 200 CIVIC AVE., SALISBURY, MD. 21804	
State Registrar 31. Date filed (Month, Day, Year) 2005 32 Registrar's Signature	

			For Stata	State of	of Maryland /				l Mental Hy	00	0.0	05000
			Registrar  1. Decedent's Name (First, Middle	a Lacti		Certificat	e or D	eam	2. Date of D	Rag. No.	105	3. Time of Death
	Physici	an	Alice Irene	Doud					October	Day	2005	5:35 A M
	/Medio Examin		4a. Facility Name (If not institution		mber)	4b. City,	Town, or L	ocation of De			unty of Death	J.J. //
1	Examili	CI	Homewood Reti	rement Co	nter		Wi	illiams	sport		Washin	aton
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last b	oirthday) If Under Months	1 Year	If Under 24 H Hours Mi	rs. 8. Date of Bi	rth	9. Birtho	place (State or Foreign
	Director		212-05-1910	1 □ M 2 💢 F	96	Yrs.	Days	Trodis in	Sept. 2	7,1909	Mar	y land
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Location	·				1	0d. Inside City Limits
	Manyl f sho	ō	Manuford Mas	hington		lal i l l	liamsp	ort				1 □Yes 2 No
	the 728a	rec	Maryland Was  10e. Street and Number	irrigron		10f. Zip		301 1		10g. Citizen	of What Cour	ntry?
	h with	ai D	16505 Virgini	a Ave. Ar	t. A301		217	795			USA	
	deat ems	ner	11. Marital Status	12. Was Dec	edent Ever in U.S.	13. Was Dece			(Specify Yes or Nerto Rican, etc.)	0- 14.	Race - Americ Black, White,	an Indian,
98	or Ite	by Funeral Director	1 Never Married 2 Marr	ried 1 Tes	2 <b>X X</b> to ive	1 ☐ Yes		Specify:	o. 10 1 110 di 11, 010.7		ecify:	oto.
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show the Medical Exami at must be notified at		3 Widowed 4 □ Divorced	Year or D		a. Decedent's Usua	al Ossusati	100		10h Kind	of Business/In	hite
5	in 72 n "na n	ojete	(Specify only highe	st grade completed)		(Give kind of wo	rk done dui se retired)	ring most of w	rorking	100. Kind C	Dusiness/in	dustry
212	d with giene.	Completed	Elementary/Secondary (0-12)	College (	1-40r 5+)	Но	ousewi	ife			Home	
	2 should be filed within 72 hours after deal and Mental Hygiene. Ie marked other than "natural", or Items:	Be C	17. Father's Name (First, Middle,	Last)			1		ame (First, Middle			
yla	ould b Ment arke	To	Charles Raymo					Elizat			Sinn	
Maryland	12 sh h and h em 7 ie m		19a. Informant's Name/Relations			b. Mailing Address	•					
	1 and Healt em 2		Elizabeth Scarb	orougn -	20b. Place	of Disposition (Nat	ne of	1	Date		on - City or To	21061 own, State
JO.	ages ant of it: If It		XXBurial 2 Cremation 4 Donation 5 Other (S		State	ery, crematory or c athedral			.21,2005			•
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any highty or other treumatic event, the Medical Examinar must be notified at ances.		21. Signature of Funeral Service		INEW O			of Facility H	ome,P.A.	irving	TON, Ma	
ã	permi Deper Impor any ir		) winh	(She					gue St.Wi	Iliams	port,M	21795 aryland
			23a. Part1. Enter the olsease, or shock, or heart failure. List	complications that	caused the reath. Do							Approximate
	Pnysician	0 1	Immediate Cause (Final disease or condition			Tuch!					100	et and Doth
	/Medical Examiner		resulting in death)	Due to	(or as a consequence						-	- 13
	LAGITITIE	_	Sequentially list conditions,	b	(or as a consequence	2.47						
	ted	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<b>2</b> 000 to	(or as a consequence	a ory.						
ď,	execu n and al-tra	Exar	that initiated events resulting in death) Last	c. Due to	(or as a consequence	e of);						
8760,	icate be executed physician and s the burial-transit	dical Examiner		d								
9		0	IF FEMALE:	1							1	
Вох	ath ce ttendii or use	an/I	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live i	tcome of pregnancy birth 2 Petal dear					23d.	Date of delive	ery Day Year
0.	The law requires that the death certific ate has been signed by the ettending p page 2 should be detached for use as	Physician/M	1 ☐ Yes 2 No 9 ☐ Unknown	4□Preg	nant at time of death lown	5 Other (sp	ecify)				Month	ouy rour
4	that the od by detac		Part II. Other significant condition	ons contributing to c	leath but not resulting	in the underlying o	ause given	in Part I.	23e. Did	tobacco use o	contribute to the	ne cause of death?
Records,	ulres sign ld be	d by	( coson 1)10	n DIE	= (CC (= (=	arrada	200	$n \subset n$	1 🗆	Yes 2 N	o 3 Prob	ably 4 Unknown
õ	w requires been signatured in should	lete	DALOXYKI	1418 A	TRICAL F	BACC	ATIG	_	24a. Was	an 24	b. Were auto	psy findings available
Re	The law	Completed	111111111111111111111111111111111111111	11		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			auto perf	psy ormed2 2 No	prior to condeath?	impletion of cause of
Vital		BeC	25. Was case referred to medica examiner?	I			2	26. Place of D	eath (Check only	~	12.00	20,110
of V	0 0	Tof	1 Yes 2 No		Inpatient 2 ER/C			Nursing	Home 5 ☐ Res	idence 6 🗆	Other (Specify	v)
		iuo	27. Manner of Death  1 Natural 5 ☐ Pendir	19	of Injury 28b. oth, Day Year)	Injury	8c. Injury a Work?		28d. Describe	how injury oc	curred	
isio	Attending or death. ector: After by the fune	icat	2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	not be	e of Injury - At home,	form street feeten		s 2 No	28f Location	Street and No	imber or Rura	l Route Number.
Division	or A after Direct In by	Certification:	4 ☐ Homicide determ	ined 200. Flact	ling, etc. (Specify)	iami, street, ractory	, onice			wn, State)	inder or Hura	r noute rumber,
_	To the Hospitei or Attent within 24 hours after death To the Funerel Director; completely filled in by the	aic	29a. Certifier 1 Certifyin	ng Physician: To the	e best of my knowled	ge, death occurred	at the time,	, date and pla	ce, and due to the	cause(s) and	I manner as st	ated.
	n 24 l n 24 l he Fu	Medical	(Check only 2 Medical one)	Examiner: On the band man	pasis of examination a nner stated.	and/or investigation	, in my opin	nion, death oc	curred at the time	date and plac	ce, and due to	the cause(s)
	To t To t	Σ	29b. Signalute and Tille of Certific	r / i.	X	290	c. License n	number		29d. Date sig	gned (Menth,	Day, Year)
)			MILLINE	-/ W	EXCER (X)	&CTU2	()/	106	)	10/1	1/50	
9 3 1			30. Name and address of person	who completed cau	se of death (Item 23a	) (Type, Print)	51	1	. 11	- 4	the.	15 TTO a .
3H-	Sta	to	31. Date filed (Month, Day, Year)	32.	egistrar's Signature	) 19	11	JUN 1 HC	~ WITU	2 1	1700	Theen
	Registi		31. Date filed (Month, Pay, Year)	3 2005	new G.	Spele					It	b=1~

		_ 1	For State Registrar	State of	f Maryland		rtment of H		Mental Hygi	ene O (	)5	35060
	Physicia		1. Decedent's Name (First, Middle Irene E. Esli						2. Date of Death Month October	Day	Year 05	3. Time of Death 1:10 PM
	/Medic Examin	al -	4a. Fecility Name (If not institution		nber)		4b. City, Town, o	Location of Deat		4c. County		
	LAGIIIII		1700 Marymont				Silver			Monte	gomery	
	Funeral Director		5. Social Security Number	6. Sex 1 ☐ M 2 🟋 F	7. Age (In yrs. la 75	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, 01/29/19	Ye <i>ar)</i> 30	Coun	lace (State or Foreign htry) ylvania
	ס	- }-	Usuel Residence of Decedent						p = / = 3 / = 3			0d. Inside City Limits
	arylan show	. 1	10a. State 10b. County MD Montge			Town or Lo er Spr						1 ☐ Yes 2 🔏No
	the M	recto	10e. Street and Number				10f. Zip Code		10	g. Citizen of	What Cour	ntry?
	h with	ai Di	1700 Marymont	Road			2090	6		U.S		
336	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23e or 28e-f show aumatic event, the Medical Expriditer must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Mar 3 ☐ Widowed 4 ☐ Divorce	ried 1 ☐ Yes	2 <b>X</b> No ⁄e		Vas Decedent of H f Yes, specify Cuba I □ Yes 2X No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	Bla	ce - Americ ack, White, fy: Whi	etc.
Maryland 21215-0036	vithin 72 horne. han "naturi	Completed	(Specify only higher Elementary/Secondary (0-12)	nt's Education st grade completed)	I-4or 5+)	(Give life. I	dent's Usual Occup kind of work done DO NOT use retired temaker	during most of wo	rking	6b. Kind of E		dustry
2	filed v Hygie other t		12 17. Father's Name (First, Middle,	Last)		11011	icmarci	18. Mother's Na	me (First, Middle, M			
lan	Aental Aental rked o	To Be	Leonard Bestwi	ck				Unknown				
Mary	nd 2 should be and he was the should be and he was the should be a		19a. Informant's Name/Relation William Eslin			19b. Mailir 1700	ng Address <i>(Str</i> eet Marymont	and Number or R Road, S	ural Route Number. ilver Spr	ing, M	, State, Zip lary1&	o Code) and 20906
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked any injury or other traumatic events.		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 4 □ Donation 5 □ Other (a		Ctata	metery, crer	sition (Name of natory or other place 1n Cremat		Date 2	oc. Location		
Balti	permit. Departm Importe any inju		21. gnatur of Funetal Service	Van 4	lut.	10	40 Rockv	ille Piko	imple Tril e, Rockvi	lle, M	ary1a	nd 20852
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that of tonly one cause on the	caused the death.	. Do not ent	er the mode of dyin	ng, such as cardia	c or respiratory arre	st.		Approximate Interval Between Onset and Death
	Prysician		Immediate Cause (Finat disease or condition resulting in death)		ratory A						2	Onset and Death Years
	/Medical Examiner				orasa consequic Obsti		e Pulmon	ary Dise	ase			
	7	ner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury		(or as a consequ							
	xecuter and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consequ	ence of):						
8760,	icate be executed physician and s the burial-transit	caiE		d								
9	ertifica ding ph	Med	IF FEMALE:	23c If yes ou	tcome of pregnar	nev				334 D	ate of deliv	90/
.O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medicai	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown	1 Live	birth 2 ☐ Fetal nant at time of de	death 3[	Ectopic pregnanc Other (specify)	у			Ionth	Day Year
٥.	se un eq	by	Part II. Other significant condit	ions contributing to c	leath but not resu	ilting in the u	nderlying cause gr	ven in Part I.	11			he cause of death? bably 4 □Unknown
Vital Records,	e law has b ye 2 sl	completed					<del></del>		24a. Was as autops perform	v		opsy findings available impletion of cause of 2 No
/ita	Physiclan: Th this certificate ral director, pag	BeC	25. Was case referred to medic examiner?	at Hospital:			0+	200	eath (Check only on			
of	ys dii	. To	1 ☐ Yes 2X No 27. Manner of Death	1 1 1		ER/Outpatie 28b. Time o	of 28c. Inju	ry at	Home 5 Reside			fy)
ion	Attending Phrdeath. ector: After thisy the funeral	ation	1 X Natural 5 ☐ Pend	ing (Mor tigation	nth, Day Year)	Injury	Wo	rk? ]Yes 2 □No				
Division	or Dir	ertification:	3 Suicide 6 Coul 4 Homicide deter	minod 200. Flac	e of Injury - At ho ling, etc. (Specify	me, farm, st	reet, factory, office		28f. Location (St. City or Town	reet and Nun , State)	nber or Run	al Route Number,
	% E = >	edical C	29a. Certifier 1 X Certify (Check only one)	ing Physician: To the I Exeminer: On the and man	e best of my know casis of examinat oner stated.	wledge, deat ion and/or in	th occurred at the to	me, date and place opinion, death occ	ce, and due to the co curred at the time, do	ause(s) and nate and place	nanner as s	stated. o the cause(s)
	To the Ho within 24   To the Fu completel	Me	29b. Signature and title of certif	ier			29c. Licen			9d. Date sign		
)	5		6 dward	Klinke	com		D127	03	Oc	tober	13, 2	2005
			30. Name and address of personal Edward J. Rich	ards, M.D	., 10301	Georg	Print) gia Avenu	e, #203,	Silver S	pring,	, Mary	land 20902
	St Regist	ate rar	31. Date filed (Month, Day, Yea OCT 1	4 2005	egistrar's Signa	ture	nerte					

35061 State of Maryland / Department of Health and Mental Hygiene 1 15 1 \_ State Certificate of Death a. No. 3. Time of Death

2005

4c. County of Death FREDERICK  $P^{M}$ 

10:01

		<ul> <li>Hegistrar</li> </ul>				00,	mout	0 0, 1	Journ		H	eg. No.
	Physician /Medical	1. Decedent's Na JACKSON					-				2. Date of Deat Month OCTOBER	Day
9	Examiner			on, give street and no			, ,	Town, or DERI	Location CK	of Death		4c. FI
Ī	Funeral Director	5. Social Security 229-38-8		6. Sex 1  M 2 ☐ F	7. Age (In yrs. las	Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Dec. 29,	Year) 19
	pu .	Usual Residence	of Decedent		10c City T	own or Lo	cation					

 Birthplace (State or Foreign Country) 1918 Virginia

10d. Inside City Limits 1 ☐ Yes 2 ☐ No Frederick Maryland Keymar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?

11250 Hill Road 21797 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: þ 3 Widowed 4 Divorced

White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4or 5+) Plant Manager High's Dairy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)

Jackson Reid Furr Catherine Hailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Thelma R. Furr (Wife) 11250 Hill Road, Keymar, Maryland 21757 20c. Location - City or Town, State 20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place) N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Utica Cemetery 10/19/2005 Utica, Maryland 4 Donation 5 Other (Specify)

21. Signature of Fyneral Service ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 Approximate Interval Between Onset and Death

Interction Immediate Cause (Final

disease or condition resulting in death) Due to (or as a consequence of)

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of):

IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 9 1 Yes 2 No

25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

36421 mosemerena defield Dr. #104 Frederick 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9093 31. Date filed (Month, Day, Year) State OCT 18 2005

Physician /Medical Examiner

other traumatic event, the Medical Examiner must be notified at

or items 23s

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyp. Important: If Item 27 is marked any Injury or other to appear.

Physician/Medical

δ

Completed

Be

Certification: To

Medical

ed by the attending physicien and detached for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 certificete hes been signe rector, page 2 should be

the Hospital or Attending Physician: this death. Director: 24 hours a within 2

Registrar

State of Maryland / Department of Health and Mental Hygien [ ] [ 5

3	5	0	6	2
	_	-	-	

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death October 12, 2005 **Physician** Corinne Elizabeth Fitzgerald 2:55 a<sup>M</sup> /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 304 Dogwood Drive Montgomery Gaithersburg 5 Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year 12/30/1952 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 ☐ M 2(X)F 025-44-9410 52 Yrs. Massachusetts Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23s or 28e-f show any injury or other traumatic event, it s Moutou Examitiset with the motified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 □ No Director Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20877 304 Dogwood Drive U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No If Yes, Give Year or Dates: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Hospital 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elizabeth Tabor Warren Fitzgerald 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Alan Martinson - Husband 304 Dogwood Drive, Gaithersburg, Maryland 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Ft. Lincoln Crematory 10/16/2005 Brentwood, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simple Tribute exal Service 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Colon Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine attending physician and I for usa as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4 Pregnant at time of death 5 Other (specify) ed by tha a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an page 2 s has autopsy 2X No To the Hospital or Attending Physician: ours after death.

saral Director: After this certifical in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 1 Yes 2 XNo ို 3[] DOA 4 Nursing Home 5 Nesidence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funaral I

completely filled 29a. Certifier 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title o ent October 12, 2005 MD35635 OJ 30. Name and address of person o completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Joseph Kaplan,

31. Date filed (Month, Day, Year)

M.D.,

OCT 14 2005

32 Registrar's Signature

18111 Prince Phillip Drive, Suite 327, Olney, Maryland 20832

State of Maryland / Department of Health and Mental Hygie $\mathfrak{p}$  0 0 5 35063 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 12, **Physician** William Patrick Guthrie 2005 6:47P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard 11870 Simpson Road Clarksville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1☐M 2☐F August24,1953 Washington, D.C. Director 219-64-7433 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Howard Clarksville Director 10f. Zio Code 10g. Citizen of What Country? 10e. Street and Number with or items 23a or 11870 Simpson Road 21029 United States death v Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within in and Mental Hygiene.
7 Is marked other then \*! Elementary/Secondary (0-12) College (1-4or 5+) 12 Author Literary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 is marked cany injury and other treumatic and William Joseph Guthrie, Jr. Frances Phipps Kirk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory M. Guthrie -brother 11870 Simpson Road Clarksville, Maryland 21029 injuryenother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 10/17/2005 Alexandria, Virginia 21. Signature of Funeral Service Licensed 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Colon Cancer 4months /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760 attending physician an/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) Physici 1 ☐ Yes 2 ☐ No detached the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 2 funeral 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Nuicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D26287 October 14, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Berard, M.D. 7305 Baltimore Ave., #107 College Park, Maryland 20740 2. Registrar's Signature 31. Date filed (Month, Day, Year) OCT 17 2005 Registrar

		-	For State Registrar	State of Maryla	•	artment of F			2005	35064
			Registrar     Decedent's Name (First, Middle, Last	st)		tineate of	Doutin	2. Date of Dea		3. Time of Death
	Physicia /Medic		Richard W	HARD GA	4/100			Month -	12 - 200	
	Examin	er	4a. Fecility Name (If not institution, give	street and number)			r Location of Death		4c. County of De	
			Laurel Regional Ho		rs. last birthday)	If Under 1 Year	urel  If Under 24 Hrs.	8. Date of Birth	Prince G	eorge 'S
	Funeral Director			X M 2 F	80 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day NOV. 14,	1924 II.	linois
	and *		Usual Residence of Decedent  10a, State 10b, County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Maryli -f sho	to	Maryland Prince G	eorge's Be	eltsvill	.e				1 □Yes 2 🛱 No
	th the or 28a e notif	lrec	10e. Street and Number	7		10f. Zip Code	705		0g. Citizen of What C	
	ath wi	ral	3410 Dunnington R		11.6		705		United Sta	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show amounts in the Maryland Exam. In must be notified all ance.	by Funeral Director	11. Marital Status  1 □ Never Married 2√2 Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1√2 Yes 2 □ No If Yes, Give Year or Dates: ₩₩		was Decedent of F If Yes, specify Cub: 1 ☐ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecry Yes or No- Rican, etc.)	Black, Wh	
9	2 hou	ted	15. Decedent's Ec	ducation	16a. Dece	dent's Usual Occup	ation during most of work	ina	16b. Kind of Busines	s/Industry
215	ithin 7 ne. nan "n	Completed	(Specify only highest gra	College (1-4or 5+)	`life.	DO NOT use retire	d)		<b>.</b>	
d 21	filed w Hygier Ither ti		12   17. Father's Name (First, Middle, Last)		Grain	1 Inspect	or/Superv		Federal G Maiden Sumame)	overnment
lan	fental rked o	To Be	Willard M	lorgan	Gallup		Anna Ev	a Reinha	rt	
Maryland 21215-0036	nd 2 should be fall hand Mental hand Mental hand marked of transfer our traumatic eve	10	19a. Informant's Name/Relationship (Elizabeth A. Gall	**					r, City or Town, State, e, Maryla	
Baltimore,	ages 1 and of Header 1 and 1 a	)	20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specif	Removal from State		matory or other pla	ce)		20c. Location · City of	or Town, State
Baltir	permit. P Departme Importan any injur		21. Signature of up ray Service Lice	· ·	Z d	2. Name and Addre	ss of Facility Borgwardt	Funeral	L Home, PA	
			23a. Part1. Enter the disease, or com shock, or fieart failure. List only	plications that caused the d						ryland20705  Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. Acute My	ocardia.	Infarat	ion			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con	sequence of):					
		er	Sequentially list sunditions, if any, leading to immediate	Due to (or as a con-		l'hrombosi	S			
	d d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. Cornary	Atheros	clerotic	Disease			
ó	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a con-						
68760,	cate b physic the b	dlcal		d Hyperlip	1dem1a			<del> </del>		
Box	death certificate be executed te attending physician and ad for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \)	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time	etal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of d Month	elivery Day Year
P.0	that the de led by the a detached	Phy	9 Unknown  Part II. Other significant conditions		resulting in the I	underlying cause giv	ven in Part I	23e Did to	bacco use contribute	to the cause of death?
ords,	w requires that the been signed by th should be detache	ted by						1 🗆 Y	es 2□No 3🗙	Probably 4 Unknown
Vital Record	e law	Completed						24a. Was a autops perform	sy prior to med? death?	autopsy findings available o completion of cause of ?
/ita	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hannital.		0.4	26. Place of Deat		A	
of \	hye I di	. To	1 ☐ Yes 2 X No  27, Manner of Death	Hospital: 1 ☐ Inpatient 28a. Date of Injury	2 XER/Outpatie	The second secon	4   Nursing no		ence 6 Other (Sp ow injury occurred	necify)
	nding I th. : After e funer	atlon	1 Natural 5 Pending 2 Accident investigatio	(Month, Day Yea		Wo	rk? Yes 2 □ No			
Division	after des after des Director d in by th	Certification:	3 Suicide 6 Could not be determined		At home, farm, st	reet, factory, office		28f. Location (S. City or Town	treet and Number or i n, State)	Rural Route Number,
	To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical C		nysician: To the best of my miner: On the basis of exam and manner stated.						
	To th To th	Ž	29b. Signature and title of certifier		n	29c. Licens	D0009215		29d. Date signed (Mo	* '
	5		pawrence		reus		D0003413		October 14	, 2005
			30. Name and address of person who Lawrence D. Marcu				207 Silvo	r Spring	Marulan	COROS F
	Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's S	ignature /	ules	ZO, DITAG	r obring	i rarytalk	A 2030Z
E	Regist	rar	OCT 17 20	305 harris	10 /9/					

		•	_ For	partment of Health and Mertificate of Death		ene 2005 35065
	Physicia		Decedent's Name (First, Middle, Last)     Margot Goetz		2. Date of Death	
	/Medic Examin	er	4a. Facility Name (If not institution, give street and number) 1801 East Jefferson St. #406	4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery
	Funeral Director		5. Social Security Number  061-12-2058  08	Months Days Hours Min.	8. Date of Birth (Month Day March 2	year) 1912 9. Birthplace (State or Foreign Country) Germany
	Maryland a-f show	tor	10a. State 10b. County 10c. City, Town or MD Montgomery Rockvi			10d. Inside City Limits 1 ☐ Yes 2 No
	h with the	ai Direc	1801 East Jefferson St. #406	10f. Zip Code 20852		g. Citizen of What Country? United States
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importents: If Item 27 is marked other then "naturel; or Items 23a or 28a-f show ampringing any injury googher treumatic event, Ire Medical Evaning must be retified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, Give Δ Year or Dates:	3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	i within 72 ho iene. r then "natur ine Medical	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of work n. DO NOT use retired)  Book Keeper	ing 1	6b. Kind of Business/Industry  Private Industry
Maryland 2	uld be filed fental Hyg rked other tic event,	To Be C	17. Father's Name (First, Middle, Last) Samuel Fraenkel	18. Mother's Name Ida Ad		laiden Sumame)
Mary	ind 2 shou alth and M 127 is mai ar treumai		19a. Informant's Name/Relationship (Type, Print)  Beverly Weinstein - Daughter  125	alling Address (Street and Number or Rura 524 Eastbourne Dr.	Silver S	City or Town, State, Zip Code) pring, MD 20904
Baltimore,	Pages 1 a		1X Burial 2 Cremation 3 Demoval from State Cemetery, c	rematory or other place)		Oc. Location · City or Town, State Paramus, New Jersey
Balti	permit. Departn Importe any inju		21. Signature of Funeral Service Licensee  BUT HER Old  23a. Part 1. Enter the disease, or complications that caused the death. Do not a	22. Name and Address of Facility		Home
68760,	cate be executed / Medical Examiner   Medical Exami	edicai Examiner	Immediate Cause (Final	enter the modernot dying, such as cardiac o	r respiratory arre	st, Approximate Interval Batween Onset and Death
.O. Box 6	death certifi e attending ed for use as	Physician/Me		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
S, D	The law requires that the site has been signed by the bage 2 should be detache.	by	Part II. Other significent conditions contributing to death but not resulting in the	e underlying cause given in Part I.		acco use contribute to the cause of death?
al Record		Completed	(str.2) 7:4:1/ction		24a. Was an autopsy perform	prior to completion of cause of death?  No 1 Yes 2 No
Vital	8 5 7	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2X No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpat	26. Place of Death		nce 6 Other (Specify)
Division of	ding T. After fune	ation; T	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident Accident Accident	of 28c. Injury at	28d. Describe hov	
Divis	in the	Certific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
	To the Hospitel within 24 hours a To the Funeral Completely filled	edical	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, de   Certifying Physicien: To the best of my knowledge, de	investigation, in my opinion, death occurr	ed at the time, da	te and place, and due to the cause(s)
)	Withi Com	Σ	29b. Signature and title of certifier	29c. License number		d. Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Typ	erson St., Rockville	MD 2081	52
	Sta Regist		Damien Doyle, M.D. 1801 East Jeffe  31. Date filed (Month, Day, Year)  OCT 1 7 2005  32,Registrar's Signature	forth	E FID 200.	

			For State Registrar	State of Ma	aryland		rtment of H		and Ment		ene ()	05	35066	6
	Physicia	an	1. Decedent's Name (First, Middle, Last)	CADNED					M	ate of Death	Day	Year	3. Time of Death	
	/Medic	al	INEZ MARIE  4a, Facility Name (If not institution, give s	GARNER			4b. City, Town, or	Location o		TOBER	13, 20	005 y of Death	8:35 P	M
	Examin	er	125 ALLNUT COURT,		2		PRINCE F					ALVER		
	Funeral		5. Social Security Number 6. Sex	7. Age		st birthday)	If Under 1 Year Months Days	If Under 2	24 Hrs. 8. Da Min. (A	ate of Birth fonth, Day, Y			place (State or Forei	ign
	Director	,	224-30-2779	M 2Ã0 F	75	Yrs.			NOV	7,1	929	VIR	GÍNIA	
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limi	its
	Many a-f sh	tor	MARYLAND CALVERT				PRI	NCE F	REDERIC	CK			1 ☐ Yes 2X N	40
	or 28	Olrec	10e. Street and Number				10f. Zip Code			10	g. Citizen of	What Cou	ntry?	
	ath w	rall	125 ALLNUT COURT,	APT. #212		10.1		0678	-1-2 (5		UNITEI		TES can Indian,	
<b>'</b> 0	fter de	Funeral Director	11. Marital Status  1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 Ø A	-ver iii 0.3 Vo	į	Vas Decedent of Hi f Yes, specify Cuba		i, Puerto Rican	, etc.)		ck, White,		
5-0036	72 hours after death with the Maryland natural', or iteme 23a or 28a-f show lical Examiner must be mullified at	by	XXWidowed 4 □ Divorced	If Yes, Give Year or Dates:			I□Yes XIX No	Specify:			Specia	<sup>fy:</sup> WH	ITE	
5-0	"natu	Completed	15. Decedent's Educ (Specify only highest grade			(Give	lent's Usual Occupa kind of work done of OO NOT use retired	durina most	of working	16	6b. Kind of E	Business/Ir	ndustry	
2121	withir ene. then	duic	Elementary/Secondary (0-12)	College (1-4or 5	i+)		VING CLE			D	EPARTN	/ENT	STORE	
DC 2	e filed Il Hyg other	Be C	17. Father's Name (First, Middle, Last)						r's Name (Firs					
ylaı	Menta Arked arked	To	JOSEPH A. SIMMS						TTIE TA					
Maryland	d 2 sh ih and 7 is m treum		19a. Informant's Name/Relationship (Type DONALD GARNER - SO				g Address <i>(Str</i> eet a							
re,	Heall Heall tem 2 other		20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Name of natory or other place	10	CT. Date 2		oc. Location			_
altimore,	Pages nent of int: if i		1 A Burial 2 ☐ Cremation 3 ☐ Re  '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1		BAP. CH.	, I			SPOTSY	ZLVAN	IA, VA	
Balti	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hyglene. Department of Health and Mental Hyglene Hyglene and Importent: if item 27 is marked other than "naturel", or iteme 23a or 28a-1 show any injury or other treumatic event, it a Marical Examination man be notified at once.		21. Signatur of Fugeral Service License	Raun			. Name and Addres			0.B0X	156,	WALD	20604 DRF, MD	
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused ne cause on each lin	the death.	Do not ent	er the mode of dying	g, such as	cardiac or resp	oiratory arres	st,		Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)	Rere		ONCH	romt						Orisot and Doath	
	/Medical Examiner			Due to (or as	a conseque	ence of):								
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseque	ence of):								
	ecuted and transl	Examiner	Cause (Disease or injury that initiated events resulting in death) Last											
8760,	icate be executed physician and s the burial-transit			Due to (or as	a conseque	erice or).								
687	ificate g phys as the	edic												
Вох	death certificate be executed e ettending physician and id for use as the burial-transit	Physician/Medical	23b. was decedent pregnant	3c. If yes, outcome 1 ☐ Live birth			Ectopic pregnancy					ate of deliv	,	
O. E	the dea by the et ached fo	ysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐ Unknown	time of dea	ath 5□	Other (specify)				IVI	Ontin	Day Year	
σ.	that ed b		Part II. Other significant conditions con	stributing to death bi	ut not resul	ting in the u	nderlying cause give	en in Part I.	2	3e. Did toba	cco use con	ntribute to t	he cause of death?	
rds	w requires been sign should be	ed by								1 🗆 Yes	2 DNO	3 🗌 Prol	oably 4 Unknow	٧n
of Vital Records,	aw as b 2 sl	Completed							2	4a. Was an autopsy	24b.	prior to co	opsy findings availab	ole f
<u>E</u>	Th ate pag	Соп							1	performe		death?	2E(No	
Vita	Physician: Th this certificate ral director, pag	Be c	25. Was case referred to medical examiner?  1 Yes You Ho	lospital: 1 ☐ Inpatie	مر ۵۵۶	R/Outpatien	t 3 DOA Othe	200	of Death (Charsing Home	1	-	has (C	£.1	
	g Physer this	n: To	27. Manner of Death	28a. Date of Injui	ry 2	28b. Time of Injury	28c. Injury Work	at at		Describe how			y)	7
sior	Attending I r death. sctor: After by the funer	atlo	t⊅Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				M 1	Yes 2 1	No					
Division	or Attendation of the or	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc	ury - At hon c. (Specify)	ne, farm, str	eet, factory, office			ocation (Stre lity or Town,		ber or Run	al Route Number,	
	To the Mospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 12 Certifying Phys											_
	To the Ho within 24 I To the Fu completel	ledical	(Check only 2 Medical Examir one)	ner: On the basis of and manner sta		on and/or in			th occurred at t					
ı	with To	Σ	29b. Signature and title of certifier	1.			29c. License	76/0			Date signe		Day, Year)	
1			30. Name and address of person who co	mpleted cause of d	eath (Item	23a) (Tvne		1010			0100			
1	\$10		DAVID TARDIO, MD,	110 HOSPI	TAL R	RD., S	UITE #310	, PRI	INCE FR	EDERIC	K, MD	2067	8	
	Sta Registr		31. Date filed (Month, Pay, Year) OCT 17 20	05 32. Projectra	ar's Signatu	tre	berke							

			For State Registrar		State o	of Maryla		artmen <i>rtificat</i>				lental Hy	giene ()	05	35067
	Physicia	ın	1. Decedent's Name (F									2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic	al -	DARIAN  4a. Fecility Name (If no		GAULTNEY			4h Cih	Town or	Location	of Death	OCTOBE		2005 unty of Death	8:55 AM <sup>M</sup>
	Examine	er	33380 TU	-				40. City,		STON	OI Deatii		40.00		
	Funeral		5. Social Security Num		.Sex 1 M 2 ☐ F		s. last birthday,	If Under	1 Year	If Under		8. Date of Birt	h Voas	9. Birth	place (State or Foreign
	Director		243-38-308	80	1 <b>≜</b> M 2□F	76	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da MAR 9	1929	N. C	CAROLINA
	pu k		Usual Residence of De 10a. State	ocedent Ob. County		10c. C	City, Town or L	ocation					-		10d. Inside City Limits
	Aanyle F sho	ō	MD		LBOT	133.3		STON							1 ☐ Yes 2 🙀 No
	28a-	Director	10e. Street and Number		and t		142	10f. Zip	Code				10g. Citizer	n of What Cou	
	3a or	<u></u>	33380 TUC	КАНОЕ	RIVER RO	CAC			21	1601				USA	
	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show the Madical Examiting court be motified at	Funeral	11. Marital Status		12. Was Dec	edent Ever in	U.S. 13.	Was Deced	lent of Hi	spanic Or	igin? (Sp	ecify Yes or No- Rican, etc.)	- 14.	Race - Ameri Black, White,	
36	or Ita	by Fu	1 Never Married		1 Yes If Yes, Gir	2 □ No ve		1 ☐ Yes		Specify:		,		ecify: WH	
21215-0036	hours tural'	ed b	3 Widowed 4 [	. Decedent's	Year or D	Dates:	16a Dece	dent's Usua	I Occupa	ation			16h Kind	of Business/Ir	ndustry
5	in 72 n "na'	plet	(Specify	only highest g	grade completed)		(Give	kind of wo DO NOT us	k done d	during mos	st of work	ing	TOD. KING	or Businesser	idustry
212	d with giene.	Completed	Elementary/Seconda 12	ary (0-12)	<b>0</b>	1-40( 5+)	DRY	WALL (	ONT	RACTO	R		В	UILDING	3
A	al Hygie d othar want, L	Bec	17. Father's Name (Fin							18. Moth	er's Nam	e (First, Middle,	Maiden Su	mame)	
yla I	should be nd Mental markad c	2	DAYTON LE			[						E BARLO			
GAULTNEY, Maryland	12 sh h and 7 la m raum		JOAN P. G	-					,			ROAD,			· ·
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other then "natural", or Itams 23s or 28s-f show any injury or other traumatic event, the Medical Examination until be natified at once.		20a. Method of Dispos		T/WILD	20b.	. Place of Disp	osition (Nar	ne of	1		Date		ion - City or T	
GLEN	Pages nent of int: If its iry or o		1 XBurial 2 □ C	Cremation 3		State	cemetery, cre	matory or o	ther plac		107	20/2005			RYLAND
GLEN altimore,	artme ortan injury	Ĭ	21. Signature of Fune			WO	2	2. Name an	d Addres	s of Facili	ity				
Ba	permi Depar Impor any ir			50	MER	( E 80		ELLOWS	HARE	LFEN	BEIN	& NEWN, EASTON,	AM FUI	NERAL I	HOME PA
			23a. Part1. Enter the	disease, or co		caused the de	ath. Do not en	ter the mod	e of dying	g, such as	cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Fir disease or condition		=	115	tage	Clara	Mil.	Obs	tove	twe Pu	Imina	an	Onset and Death
	/Medical		resulting in death)	- 4	Due to	(or as a conse	equence of):	CVVV	7110	-   -	•	twe Pu	15000	2	15-1 406
	Examiner -		Sequentially list condi	tions,	b										15 Tears
	ed sit	Examiner	if any, leading to imme cause. Enter Underly Cause (Disease or inju-	ing -	Due to	(or as a conse	equence of):								
	ate be executed hysician and the burial-transit	xan	that initiated events resulting in death) Las		c	(or as a conse	equence of):								
760,	s be e	calE			d										
89	ifficate g phy as the														
Division of Vital Records, P.O. Box	death certifica e attending ph ad for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pi		23c. If yes, ou	it <i>co</i> me of preg birth 2 □ Fe		⊒Ectopic pr	ecnancy				23d	. Date of deliv	,
Э.	s deal he att	sicia	in the past 12 mg			nant at time of		Other (sp						Month	Day Year
Ρ.	res that the de signed by the a be detached f	Phy	9 Unknown Part II. Other significa	ent condition	e contributing to d	looth but not re	oculting in the I	andorhijna o	71160 GIV	on in Bost I		23a Did to	phaceo use	contribute to t	he cause of death?
Š,	es ti	by	Part II. Other significa	int condition.	s contributing to d	leatii but not it	esulling in the t	indenying c	ause give	en in Pait	1.		_		bably 4 Unknown
ŏro	w require been si	etec						-				24a. Was			
Rec	The taw cate has page 2 s	Completed								-		autop perfo	rmed?	death?	opsy findings available ompletion of cause of
<u>ra</u>	ucian: Th	e Co	25. Was case referred	I to medical						26 Place	a of Deat	1 ☐ Yes h (Check only o		1 🗌 Yes	2☑No
<u>=</u>	ysicia s cert direct	To B	examiner? 1 ☐ Yes 2 No		Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3 DC	A Othe	200	ursing Ho	V		Other (Specia	fy)
100	g Phy ter thi	n: T	27. Manner of Death		28a. Date	of Injury oth, Day Year)	28b. Time o	of 2	8c. Injury Work			28d. Describe h	now injury o	ccurred	
Sior	endin sath. or: Af he fur	Certification:	2 Accident	5 Pending investigat	tion	, , , , , , , , , , , , , , , , , , , ,	,	М		Yes 2 🗆	No				
: <u>≅</u>	or Att fler de iracte n by t	rtific	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	ad   286. Place	e of Injury - At ling, etc. (Spe	home, farm, st cify)	reet, factory	, office			28f. Location (5 City or Tox		lumber or Run	al Route Number,
	pital o		00- 0		Dhualais - Tush		and dec	h	-4.46 4:						
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, to	Medical	29a. Certifier 1[ (Check only 2[ one)	Medicel Ex	Physicien: To the ceminer: On the b and man	e best of my ki pasis of examin nner stated.	nation and/or in	n occurred vestigation	in my op	ie, date ar pinion, dea	nd place, ath occur	and due to the ored at the time,	date and pla	u manner as s ace, and due t	o the cause(s)
	o the	Me	29b. Signature and titl	e of certifier	GIN III GI					e number				igned (Month,	
	F > F 0		Mun	sell	a. Si	ere		1	(4)	187	m	A	10-1	4-200	20
			30. Name and address			se of death (It	ет 23а) (Туре	, Print)	14		-1-	e ma			
1	2+IVA		Russell	A Sch	Illing D	0 55	s cyn	いしつかん	W	ta	stor	me	2160	1	
	Sta Registr		31. Date filed (Month,	1 9 200	5 32. F	Registrar's Sig	nature	2							

	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with
JOSEPH		FT / E:
HOLLAND JO	Division of Vital Records, P.O. Box 68760,	If or Attanding Physician: The law requires that the death certificate be executed

			for State Registrar AVEND#18perFH10	State of Maryla	nd / Depa O Cea	artment rtificate	of Hea	alth an		Reg. No.		35068
	Physicia		1. Decedent's Name (First, Middle, Last)  JOSEPH BENJAMIN HO						2. Date of I Month Octobe	Day	Year 2005	3. Time of Death  10:26 A M
	/Medic Examin		4a. Facility Name (If not institution, give s				own, or Lo		eath	4c.	County of Death	
			Hebrew Home of Gr 5. Social Security Number 6. Sex		gton s. last birthday)	Rock	ville	Under 24	Hrs.   9 Date of F		lontgome:	
	Funeral Director		218-56-6025	M 2□F 57	Yrs.				Hrs. 8 Date of I Min. (Month, I June 1	3, 19		place (State or Foreign intry) Cago, IL
	rland ow		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Lo	ocation						10d. Inside City Limits
	within 72 hours after death with the Maryland ene. then 'naturel', or Items 23e or 28e-f show he Nedleul Eret' if or must be notified at	ctor	MD Montgom	ery Ro	ckville	•						1 ☐ Yes 2 🛣 No
	with th	Funeral Director	10e. Street and Number	1 #2121		10f. Zip (					izen of What Cou	
	ns 234	eral	6121 Montrose Roa	12. Was Decedent Ever in	U.S. 13.			anic Origin	? (Specify Yes or I		ed State	
9	or Itan	Fun	1 ☑ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 📆 No If Yes, Give		If Yes, speci 1 ☐ Yes 2		Mexican, P Specify:	? (Specify Yes or I uerto Rican, etc.)		Black, White Specify: White	
21215-0036	hours tural',	Completed by	3 Widowed 4 Divorced	Year or Dates:		dent's Usual				16h Ki	ind of Business/li	-
7	in "naf	plete	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of work DO NOT use	k done durii	ng most of	working	100. Ki	III OI DUSIII 633/II	idustry
	filed with Hygiene other tha	Com		2	Neve	er Emp						
Maryland		To Be (	17. Father's Name (First, Middle, Last)  Joshua Zalman Holl	and			18	. Mother's Anab Anabe	Name (First, Midd el Schrib 1 Schrib	lle, Maiden eiber <del>er</del>	Sumame)	
lary	2 should be and Mental is marked ( aumatic ev	-	19a. Informant's Name/Relationship (Ty						r Rural Route Nun			p Code)
ď.	os 1 and 2 of Health itam 27 l		Joshua Z. Holland,		Place of Dispo cemetery, cre			e, Ta	ıkoma Par	7	20912 ocation - City or T	own, State
mor	Pages ent of nt: If it		12☐ Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)		cemetery, cred unt Let			10-	16-2005	Ade	lphi, M	D
Baltimore,	permit. Pages 1 Department of H Important: If its any injury or ot		21. Signature of Funeral Service Lisense	99	2:	2. Name and	d Address o	of Facility H	lines-Rin	aldi	Funeral	Home Inc.
<u></u>	82558		I allay L	onell	11	1800 N	ew Ha	mpshi	re Ave S	ilver		MD 20904 Approximate
	Fnysician /Medical Examiner		23a. Part1. Enter the disease or complishock, or heart failule. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse	0B				4 NG 1		ASE	Interval Between Onset and Death
68760,	death certificate be executed e attending physician and d for use as the burial-transit	ical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consi						,		
.O. Box	death certific e attending pl ed for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  \subseteq Yes 2 \subseteq No 9 \subseteq Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	etal death 3[	⊒Ectopic pre ⊒ Other (spe				-	23d. Date of delin	very Day Year
ls, P	es tha igned be de	by	Part II. Other significant conditions con	ntributing to death but not re	•	, ,	use given i	in Part I.	23e. Di	1	use contribute to	the cause of death?
Record	w requir been si should	Completed		19120111	CIOII					as an	24b. Were aut	opsy findings available
	The lav	Somp							— au pe 1 ☐ Yes	topsy rformed? 2 No	death?	ompletion of cause of 2□ No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Other:	. /	Death (Check onl			
o		on; To	Yes 2 No  27. Magner of Death  A Natural 5 Pending	1 ☐ Inpatient 2  28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury		Bc. Injury at Work?	1	ng Home 5 □ Re 28d. Describ			fy)
Division	Attanding or death. ector: Alter by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At		M reet factory		2 □ No	28f. Location	(Street an	d Number or Ru	ral Route Number,
Οį	i Sir de	Certif	4 Homicide determined	building, etc. (Spe	cify)	· oot, ractory,				Town, State		
	To the Hospital within 24 hours a To the Funeral completely filled	Medical		sicien: To the best of my k ner: On the basis of exami and tanner stated.								
2	within To th	Me	29b. Signature and title of certifier	1 > -		29c.	License nu	umber	-11	29d. Dat	te signed (Month	, Day, Year)
	10		> Dinell	& M	hw)		1) (	10	8-4	UC	10BER	13,2005
	10		30. Name an address of person who co	ATEC, Med	2 621-	Print) 17	ONTR	208	20,8	leci	e VILLE	13,2005
₹.	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  OCT 1 7 20	32 Registrar's Sig	h fo	rike						

		For State Registrar	State of Maryland		artment o		Я	leg. N2 0 0 5	35069
Physici /Medic		1. Decedent's Name (First, Middle, Last)  Ida Mae Harg:					2. Date of Dea Month Octobe	r 10 200	8:52 A M
Examin	er,	4a. Facility Name (If not institution, give s			4b. City, Tow	n, or Location of De		4c. County of De	
*	. ·	Southern Marylan  5. Social Security Number 6. Sex		st birthday)	If Under 1 Ye	Clintor par   If Under 24 F	Irs. 8 Date of Birth		ce George's
Funeral Director			M 2 F 80	Yrs.	Months Da	ys Hours M	in. (Month, Day May 1,	1925 V	irthplace (State or Foreign Country) Vash., DC
a-f ehow	ctor	10a. State 10b. County DC	10c. City,	Town or Lo		Washingto	on		10d. Inside City Limits 1 X Yes 2 ☐ No
्त का 10 7 28	Director	10e. Street and Number			10f. Zip Cod			10g. Citizen of What (	
ath w	rai		Road, S.E.  12. Was Decedent Ever in U.S	12	Mas Deceded	20019	(Consider Van as No.	United	States
within 72 hours atter death with the Maryland ene. then "natural", or iteme 23e or 28e-f ehow ite Medical Exeminar must be nutified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Amed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify (		(Specify Yes or No- erto Rican, etc.)	Black, Wh	
thin 72 houe.  e.  matura	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give life.		ine during most of tired)		16b. Kind of Busines	s/Industry
ed wit ygjen wer th	Con	12th		Re	ception	ist/Secre			nment
wild be fill Mental Hi arked oth	To Be	17. Father's Name (First, Middle, Last) Samuel Ki	nights			18. Mother's f	Sarah P	. Taylor	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or iteme 23a or 28a-f ehow any injury or other traumatic event, it a Medical Examinat must be nutitied at once.		John Lewis Hargra  20a. Method of Disposition  1 \( \) Burial 2 \( \) Cremation 3 \( \) R  4 \( \) Donation 5 \( \) Other (Specify)  21. Signatur 1 Fundral Service License	emoval from State $ ext{Cel} \mathcal{F} \mathbf{t}$ .	ice of Dispo metery, crei Linco	osition (Name of matory or other old Cem 2. Name and Ac	place) etery 10	/15/2005 Stewart	DC 2001 20c. Location - City of Brentwo Funeral Ho Wash., DC	or Town, State
Medical Examiner physicien end the priral-transit	cal Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence).  Due to (or as a consequence).  Due to (or as a consequence).	ence of):					
death certitic e attending p id tor use as i	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal o 4 □ Pregnant al time of dea 9 □ Unknown	death 3[	Ectopic pregn: Other (specify			23d. Date of d Month	elivery Day Year
res tha igned be de	d by P	Part II. Other significant conditions con  CAAUEA OF So	atributing to death but not resul	ting in the u	nderlying cause	given in Part I.	23e. Did to	<b>.</b> .	to the cause of death? Probably 4 ⊟Unknowr
The ate h page	Completed by							med? death 2 No 1 ☐ Ye	autopsy findings available completion of cause of s 2 \square No
Phys this ral dir	tion: To Be	27. Manner of Death  1 Natural 5 Pending	1	R/Outpatier 28b. Time o Injury		Other		nel ence 6 Other (Sp ow injury occurred	pecify)
or Atten after deat Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - Al hon building, etc. (Specify)	ne, farm, st			28f. Location (S City or Tow	itreet and Number or i n, State)	Rural Route Number,
he Hospital in 24 hours e he Funeral D pletely filled i	edicai	29a. Certifier 1 Certifying Physical Check only one)	sicien: To the best of my knowner: On the basis of examination and manner stated.	riedge, deat on and/or in	h occurred at the vestigation, in r	e lime, date and pl ny opinion, death o	ccurred at the time, o	date and place, and d	ue to the cause(s)
To the twithin 2.	W	29b. Signature and title of certifier			-	ense number	71-	29d. Date signed (Mo.	
2(3)		30 Name and accress of person who co	impleted cause of death (Item	23а) (Туре,	Print) Lik	ie Cell	TEL WA	LOONE, X	10, 2000 Ad. 2060
Sta Regist	ate rar	31. Date filed (Month, Day, Year) 0CT 1 7 2005	3. Registrar's Signatu	ho	de			,	

			For State Registrar	State of M	aryland / Depa	artment of F			Reg. No.	5 35070			
	Physici	an	Decedent's Name (First, Middle, Las     Drewry		h HARPOLD			2. Date of De Month	Day	3. Time of Death			
	/Medic	40.00	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of [	Death Control	4c. County of	205   15:15 M			
	ST		Washington County			Hagers		Hrs. I - a - i a	Washi				
7	Funeral Director		5. Social Security Number 6. Se 212-62-4356	X 7.A	ge (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days		Min. 8. Date of Bird (Month, Da March	y, Year)	9. Birthplace (State or Foreign Country) Virginia			
	ס		Usual Residence of Decedent		140-01-			, itaz ett	-,,1,1,1				
	Aarylar I show	ō	10a. State 10b. County Maryland Washingt	on	Hagerstow					10d. Inside City Limits 1 ☐ Yes 2 🛣 No			
	r 28a-	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?			
	23a o	raiD	114 Sundown Cour	t 1-C		21740	-		U.S.A				
36	4 within 72 hours after death with the Maryland Jene. r then "netural", or Items 23a or 28a-f show the Medical Examinet must be neillised at	by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 Yes 2 4 If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2점 No	lispanic Origin an, Mexican, F Specify:	n? (Specify Yes or No Puerto Rican, etc.)	- 14. Race Black Specify:	- American Indian, , White, etc. white			
21215-0036	72 ho	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occup	durina most o	f working	16b. Kind of Bus	iness/Industry			
121	within ene. then "	ompi	Elementary/Secondary (0-12) 0-12	College (1-4or	5+)	k and le	*		weight:	management			
DC 2	E F F	Be C	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle,	Maiden Sumame	)			
ylar	should be nd Mentat marked o	ToE	Charles R					Norma Br					
Maryland	and and list m		19a. Informant's Name/Relationship (7 George M. Harpold			-		or Rural Route Numbe , Frostbur					
Baltimore,	0 0		20a. Method of Disposition  1 🔀 Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify		20b. Place of Dispo cemetery, cre- Resth	esition (Name of matory or other place aven L Gardens	Oc	tober 19,		City or Town, State			
Balti	permit. Pag Department Important: I sny Injury o once.		21. Signature of Funeral Service Licen		- / 2	2. Name and Addre	ss of Facility	Minnich	Funeral				
8760,	Physician /Medical Examiner  portion and prival-transit	ai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	s a consequence of): s a consequence of): s a consequence of):	ROTIC CA	4R1010	VASCUL	AR DISE	EASG 3 hours.			
O. Box 6	at the death certificate be executed by the attending physicien and tached for use as the burial-transit	ed by Physician/Medical	nysician/Medic	nysician/Medic	nysician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	]Ectopic pregnancy ] Other (specify) _			23d. Date Mont	of delivery th Day Year
Δ.	w requires that been signed b should be deta		Part II. Other significant conditions of	ontributing to death	but not resulting in the u	nderlying cause giv	en in Part I.			oute to the cause of death?  B Probably 4 SUnknown			
Vital Records,	The lar ate has page 2	Completed						24a. Was autor perio 1 🗌 Yes	osy pr ermed? de	ere autopsy findings available for to completion of cause of eath?			
Vita		o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	MEDIO	oth	05	Death Check only o					
of	ding Phys T. After this funeral di	l Ha	27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpat 28a. Date of Inj (Month, D	ury 28b. Time o	f 28c. Injur	4 🔲 Nursi		how injury occurre				
Division	I or Attending after death. Director: After I in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir	njury - At home, farm, st etc. (Specify)				Street and Numbe vn, State)	r or Rural Route Number,			
	To the Hospital or Al within 24 hours after or To the Funeral Direc completely filled in by	edical C			t of my knowledge, deat of examination and/or in tated.								
	To the within To the Comp	W	29b. Signature and title of certifier	7 ma	7	29c. Licens				(Month, Day, Year)			
6	4-10		MANZAR. 3	SHUP	death (Item 23a) (Type, 1 368 m	ell Str	rul-1	Hagerst	rum F	5-05 1021740			
4	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  OCT 18 20	32. Regis	trar's Signature	will		<b>V</b>					

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Drewy Elizabeth Harpold

State of Maryland / Department of Health and Mental Hygien

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J	J	U		

					Cer	tificat	e of	Death			Reg. No.	J ()	330	1 1
		1. Decedent's Name (First, Middle	, Last)							2. Dete of Dec	eth		3. Time of	Death
	Physician /Medical	Margie Ellen HIXON							Octobe	r 16, 2	Year 005	8:35	p.m.	
	Examiner	4a Facility Name (If not institution	, give street end numbe	r)			4	b. City, To	wn, or Lo	cation of Deeth				
		Williamsport N	ursing Home	2	Williams					port	Was	hingt	on	
	Funeral	5. Social Security Number		Age (In yrs. lest i	birthdey)		1 Year	If Under	24 Hrs.	8. Date of Birt	h · Vaarl	9. Birth	lace (State of	r Foreign
	Director	218-50-3582	1 □ M 2 🔀 F	97	Yrs.	Months	Days	Hours	Min.	March	13,1908	Mary	Tand	
	9	Usual Residenca of Decedent												
	lyler lyler	10a. State 10b. County 10c. City, Town or Location									1	0d. Inside Cit		
	ct s	Maryland Wash	ington	H	ager	stowr	1						tX□ Yes	2□No
	vith the Ma t or 28e-f e be nothing Director	10e. Street end Number				10f. Zip					10g. Citizen of \		ntry?	
	72 hours effer death with the Maryland natural; or items 23a or 28a-1 show dical Examinar must be notified at seed by Funeral Director	201 Devonshire	Road				= :	21740			US	A		
	filer death v r items 23d niner must Funeral	11. Marital Status	12. Was Deceder Armed Forces		13. V	Vas Dece	dent of H	ispanic Orl	gin? (Spe	ecify Yes or No- Rican, etc.)		a - Americ		
ဂ္ဂ	at a T	1 Never Married 2 Marri				_		Specify:	, , , , , , , , , , , , , , , , , , , ,	incari, otor,	Specify	_	hite	
8	ural', o	3 ☑ Widowed 4 ☐ Divorced	Year or Dates	:							Эрвсп	,.		
<u>γ</u>	ed within 72 ho ygiene. Ner than "natura nt, the Medical E Completed	15. Decadent (Specify only highes	s Education t grede completed)	16	a. Deced	ent's Usu kind of wo	al Occupa rk done d	ation during mosi f)	t of worki	ng	16b. Kind of B	usiness/Ind	dustry	
21215-0020	H Per I	Elementery/Secondary (0-12)	College (1-4or	r 5+)							1	1		
7	C F T S	O 17 Fatharia Nama /First Middle /	0			home	nake		4- 51	(P) - 1 0 0 1 1 1	her o		ome	
ă E	Se Se H	17. Father's Name (First, Middle, I	.HSI)					18. Mothe			Maiden Suman	16)		
<u> </u>	Mant Mant Marke	Irvin Thomas								ulia Mc				
Maryland	lest is m rsun	19a. Informant's Name/Relationsh									r, City or Town,			
4	and aalth m 27 her t	Larry W. Balthu	s - grandsc				_	lows	RTAG		rstown,			
5	of H if ite or of	20a. Method of Disposition 13 Burial 2 ☐ Cremation	3 □Removal from State	20b. Place camer	of Dispos le <i>ry</i> , crem	etory or o	ne of ther plac	е)	1	Date	20c. Location -	City or To	wn, State	
<u>ב</u>	ant:	4 ☐ Donation 5 ☐ Other (Sp		Rest	Have	en Ce	mete	ry	10	/20/05	Hagers	town	, Mary	1and
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Manlet Hygiene. Popertment of Health and Manlet Hygiene. Insportant: If them 27 is marked other than "natural; or item 27 is marked other than "natural; or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	21. Signature of Funeral Service L	icensee	<b>-</b>	22.	Name an	d Addres	s of Facility	y M	INNICH	FUNERAI	HOM	E	
Ш	2012	SCATA	MILL	mi C	41	L5 E.	Wil	son E	Blvd.	, Hager	stown,	Md.	21740	
		23a. Pert1. Enter the disease, or shock, or heart failure. List of	complications that cause	ed the death. Do	not ente	r the mod	e of dying	g, such as	cardiac o	r respiratory arr	est,	1	Approximate	)
F	hysician	Shook, of Hour failule. List	one cause on eech									1	Interval Betw Onset and D	reath
1	/Medical	Immediate Cause (Final disease or condition	0		1		c. L.	C				!		
	Examiner	resulting in death)	e	Due to (or as			17	Tai	IUY	2		1	yea	
	je je		0.4									1		_
	and rensi	Sequentially list conditions.	Ь	Due to (or as			2 12					-	jear.	>
o	eath certaincate be associated attanding physician and for use as the burial-trensit cian/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	10	1 60 1		~	00 0 1							
68760,	yslc he bi	that initiated events resulting in death) Last	cOL	Due to (or as e			1161	117	12				jear	5
9	Med Wed	resulting in death) Last										i		
	anding r usa a	'	d											
	raw requires that the detain of as been signed by the attand is 2 should be datached for us inpleted by Physician/	Part II. Other significant condition	s contributing to death	but not resulting	in the un	derlying c	ause give	en in Part I.		23b. Did to	bacco use cor	tribute to	the cause of	f death?
P.0	by the	^								1 🗆 Y	es 2 No	3 Prob	ably 4 □ U	Jnknown
s,	bedge de de	Anemia												
Division of Vital Records,	been signal should t	P 1 C'								24a. Was e	n autopsy	24b. We	ere autopsy fir ulable prior to	ndings
ပ္က	s bec	Renal Fail	ice							perfor	ned ?	cor	npletion of ca	
ř	ne law requir									TOW	a z No		]Yes 2□ N	No
<u>ra</u>	artificat letor, p	25. Was case referred to medical						26 Place	of Dooth	(Check only or		1 -	1162 2	10
5	his cart il diract	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpat	ient 2 ER/C	Jutnationt	3[] DO	Othe	vr. /			ence 6 □Othe	· · /C- · · · · ·		
ō	artis	27. Menner of Death	28e. Date of Inj	ury 28b.	Time of		8c. Injury Work				w injury occurr		7	
ב ס	tion a fundamental	1 1 Naturel 5 ☐ Pending 2 ☐ Accident investiga		ay Year)	Injury	М		:? /es 2 □ N						
<u> S </u>	r dea	3 ☐ Suicide 6 ☐ Could no	ned 286. Place of In	ijury - At home, t	farm, stre	et, factory	, office		2		reet and Number	er or Rura	Route Numb	er,
5	rs effer death.  led in by the funers  Certification:	4 Homicide	building, e	tc. (Specify)						City or Town	n, State)			
	ai C	29a. Certifier 1 Certifying	Physician: To the best	of my knowledg	e, death	occurred a	at the tim	e, date and	place, a	nd due to the ca	ause(s) and ma	nner as st	ated.	
2	To the hours either death.  Within 24 hours either death.  To the Funerel Director: After this cartificate has completaly filled in by the funeral director, page 2 medical Certification: To Be Completed.	(Check only 2 Medical E	xaminer: On the basis of and manner si	of exemination a	nd/or inve	estigation,	in my op	inion, deatl	n occurre	d at the time, d	ate and place, a	ind due to	the cause(s)	
	Withir Comp	29b. Signature and title of certifier				29c	. License	number			9d. Date signed			
		Cynthia	Kuttner-	Sand	a ma		D4-	145	1		October	-17.	2001	5
	ì								1					
31	1-2	Bunthis Kuttone	- Sands M	D WILL	com S	port	Nuc	sing 1	tom	2, 154	MOCTA	TTTT	izan	الممما
	State	31. Date filed (Month, Day, Year)	32. Hengrist	rar's Signature						STRE	I, Willia	ALROO!	Mary	TOCING
	Registrar	31. Date filed (Month, Day, Year)	2005	m B.	1	1. 18 1								
DHM	H 16 Rev 6/95		Monrel	, <u>// .</u>	popular	rand								

	Perry l	Har	rison Sr.  1- State Registrar		faryland / De		t of H	ealth an	d Mental Hy		nns	35072	
			Decedent's Name (First, Middle, Last	1)					2. Date of De	ath	V-U-U-	3. Time of Death	
н	Physici /Media	_	Hank Perry Harrison Sr.					October	12.	2005	12:47 P <sup>M</sup>		
	Examir							Location of D			ounty of Death		
			Howard County Gen			Colu			10		Howard County		
г	Funeral		5. Social Security Number 6. Se	x 7. A X3.M 2 □ F	ige (In yrs. last birth	Months		If Under 24 Hours	Min. (Month, D.	ay, Year)	9. Birth	place (State or Foreign intry)	
	Director		216-86-7637 Usual Residence of Decedent		40				Feb. 20	1,1965	Mar	yland	
	yland		10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits	
	B Mar	ctor	Maryland Carrol	.1	Mt. Ai	ry						1 ☐ Yes 2X No	
	or 28	Director	10e. Street and Number			10f. Zip	Code			10g. Citize	n of What Cou	intry?	
	ath w		205 Frederick Aven			10.111 5		771	2/0		ted Sta		
36	s within 72 hours after death with the Maryland liene. r then "netural", or Reme 23a or 28e-f ehow the Madical Examiner must be incliffed at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1  Yes 2  If Yes, Give Year or Dates	5? ₫ No	If Yes, spec		n, Mexican, P Specify:	? (Specify Yes or No Puerto Rican, etc.)		Black, White		
Maryland 21215-0036	2 hou	ed	15. Decedent's Ed	ucation	16a. C	Decedent's Usua	al Occupa	ation		16b. Kind	of Business/I		
215	within 72 ene. than "net	Completed	(Specify only highest grad	College (1-4o		Give kind of wo life. DO NOT us	rk done d se retired	during most of ")	i working	High	πργ γεν	inistration	
7	filed with Hygiene. ther the	Con	12			Su	perv				-	inistration ty Roads	
nd	d be filed ntal Hyg ed others:	Be	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Middle	, Maiden S	umame)		
yla		은	Gerald N. Harrison		105	4-10- 4-44	(C11		ae Colson	Oit	Farra Chara 7	:- C- /- \	
Mai			19a. Informant's Name/Relationship (7			_			or Rural Route Numb				
	1 and 2 Health tem 27		Kathy L. Harrison/ 20a Method of Disposition	wile	20b. Place of D	Disposition (Nar	ne of		e, Mt. Ai		tion - City or		
OL			1 🖾 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		0	, crematory`or o		1	10/18/05	Moodh	ino M	awal and	
Baltimore,	permit. Page Department of Importent: If eny injury or once.		21. Signature of Funeral Service Licens		Jenning	22. Name an	nd Addres	s of Facility					
ä	Den Period		It add DC	Knu		26401 <sup>L</sup>	. Mo. Ridg	leswor e Road	th P. A. I Damascus	Funera 5, Mar	ıl Home Yland	20872	
			23a. Part I. Enter the disease, or composhock, or heart failure. List only	olications that caus	ed the death. Do no							Approximate Interval Between	
}	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		as a consequence of		Rnn	Nasu	LAR DI.	SEA3	=	Onset and Death	
	Examiner		Sequentially list conditions, b.										
	ed sit	-lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):										
	e be exec ted /sicien and e burial-tr: nsit	xan											
760,	le be e ysicien e buri	<b>g</b>											
89	death certificate be exec. ted e ettending physicien and od for use as the burial-tr. nsit												
Вох	h cert endin r use	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							23	d. Date of delir	,	
	deat	108								Month Day Ye			
P.0	The law requires that the deate has been signed by the rage 2 should be detached	P.	9 Unknown						20- 0:4				
	res tha igned I be det	þ	Part II. Other significant conditions co	ontributing to death	but not resulting in t	the underlying o	ause give	en in Part I.		Yes 2		the cause of death?	
orc	w require been sig	Completed				·							
3ec	e law has b	Jd L							24a. Was	s an opsy ormed?	24b. Were aut prior to c death?	topsy findings available ompletion of cause of	
of Vital Records,									Yes	2 🗆 No	Yes	2□ No	
ž	Physiclen: rthis certific ral director,	Be C	25. Was case referred to medical examiner?  1    Yes 2   No	miner?									
	Phys or this aral dii	7: To	27. Manner of Death	28a. Date of Ir	ijury 28b. Tii	me of 2	28c. Injun Worl	4   Iduisi	28d. Describe			iry)	
lon	nding f th. : After e funer	at lor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, L	Day Year) Inj	ury M		k? Yes 2.∐No					
Division	Hospitel or Attending 24 hours efter death. Funeral Director: After tely filled in by the funer	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospitel or within 24 hours efter To the Funerel Dir completely filled in	Medical C	25a Control 1 Certifying Phr (Check only one) 2 Medical Exam	ysician: To the bei iner: On the basis and manner	of examination and	dauth decurred for investigation	at the tin	ne, date and p pinion, death	clade, and due to the occurred at the time	causo(s) a , date and p	ndarmer se lace, and due	etated. to the cause(s)	
	Fo the	₩.	29b. Signature and title of certifier			290		a number		29d. Date	signed (Month	, Day, Year)	
	-3-0		) Quets				OCI	Œ		Octob	er 13,	2005	
	15		30. Name and address of person who o		f death (Item 23a) (T	Type, Print) 11	.1 Pe	enn Str	reet Balt			and 21201	
	St	ate	31. Date filed (Month, Day, Year)		strar's Signature	_							
	Regist	rar	OCT 172	005	en 15	Soule	,		·				
DH	IMH 17 Rev 1/2	2001		-									
					OR	IGINAL							

State of Maryland / Department of Health and Mental Hygiene 0.05

35073

			1 - State Registrar			Cei	rtificate of	Death		Re	eg. No.	00010
- 1			1. Decedent's Name (First, Middle,	Last)					2	Date of Deat		3. Time of Death
	Physicia		Louise	Jackson						Month October	Day Yes	4.4
·	/Medic Examin		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City, Town, o	or Location of			4c. County of D	
			Holy Cross He	ospital			Silv	er Sp	ring		Mon	ntgomery
	Funeral			. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 2		. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
	Director		579-48-9110	1 □ M 2 □ XF	7	1 Yrs.	Months Days	Hours	Min.	ov. $24$		Country) Orth Carolina
-			Usual Residence of Decedent		•	-	<u> </u>		ди	OV 6 2-79	1733 N	orth Carotina
	ow ow		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation					10d. Inside City Limits
	Mary f sh	jo	DC				LIO C	himata				1X Yes 2 ☐ No
	28a-	Director	10e. Street and Number				10f. Zip Code	hingto	OH	1	0g. Citizen of What	Country?
	be filed within 72 hours after death with the Maryland ital Hyglene.  delther than "natural", or itema 23a or 28a-f show other than "natural", or itema 23a or 28a-f show event, I're Medical Examinar must be notified at			- 2nd St	- N E			200	002			
	a 23	Funeral			edent Ever in U		Mas Donadant of I			fu Von ar Na		1 States
	er de	ū	11. Marital Status	Armed Fo	orces?	7.3.	Was Decedent of I f Yes, specify Cub	an, Mexican,	, Puerto Ric	can, etc.)	Black, W	hite, etc.
50	within 72 hours after ene. than "natural", or Ite the Medical Examina	by F	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	d 1 ☐ Yes If Yes, Gir Year or D	ve		1 ☐ Yes 2 📉 No	Specify:			Specify:	African
3	hour	d			/al65.	100 Dans	damilia Marrial Consu					American
212-0030	"nat	Completed	15. Decedent's (Specify only highest	grade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most	of working		16b. Kind of Busine	ss/industry
N	vithir ne. hen	mp	Elementary/Secondary (0-12)	College (	1-4or 5+)				07 1		_	
N	ygie ygie ygie t, th		12th	- 4)		1	ransport					ernment
מחמ	d oti	Be	17. Father's Name (First, Middle, La					18. Mother	rs Name (		Maiden Sumame)	
<u>a</u>	Men Men arke	10	George I	arrison						Eliza	beth Fais	son
Mar	and and		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street	and Numbe	r or Rural F	Route Number,	, City or Town, State	e, Zip Code)
Ξ	alth alth		Charity Jacks	son / Dau	ighter	2023	- 2nd S	t. N.	E. Wa	ash D	C 20002	
9	es 1 and 2 should be f of Health and Mental H f Item 27 ie marked ot r other traumatic eve		20a. Method of Disposition		20b.	Place of Dispo	sition (Name of natory or other pla		Dat		20c. Location - City	or Town, State
Ē	Page ent c nt: tf ry or		1X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State		Nat. Mem		10/18	3/05	Laure	el, MD
Бащтог	artm orta inju		21. Signature of Funeral Service Li-		$\cap$						neral Hon	
ď	permit. Pages Department of t important: If ite eny injury or of		) WILL	Stewa	+ 111	,					Wash., DO	
· Ar	77		23a. Part1 Inter the disease, or c		aused the dea	th. Do not ent						Approximate
			shock, or heart failure. List or	nly one cause on e	each line.		,	3.		,		Interval Between Onset and Death
Sec.	Physician		Immediate Cause (Final disease or condition resulting in death)	_ aMet	astatio	c Small	lung ca	ncer t	o bra	in		11/02-10/05
	/Medical Examiner		rosalting in doutin)	Due to	(or as a consec	quence of):	_					
	1,5	_	Sequentially list conditions,	b						· · · · · · · · · · · · · · · · · · ·		
	D #	Examiner	if any, leading to immediate cause. Enter Underlying	Due to	(or as a consec	quence of):						
	and Ind trans	am	Cause (Disease or injury that initiated events resulting in death) Last	c								
Ď,	e exe ien a iriat-		resulting in death) Last	Due to	(or as a consec	quence of):						
68/6U,	certificate be executed iding physicien and ise as the burial-transit	/Medical		d								
	tiffice ng pt as tl	Med										
ŏ	~ 5 3	L.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregn		Ectopic pregnanc	.,			23d. Date of	
מ	death e atter	icia	in the past 12 months?	4∐Pregr	nant at time of		Other (specify)	y 			Month	Day Year
)	w requires that the deatt been signed by the atte should be detached for	Physicia	9 Unknown	9□ Unkn	own							
7	requires that the een signed by th hould be detache	by P	Part II. Other significant condition	s contributing to d	eath but not re	sulting in the u	nderlying cause giv	ven in Part I.		23e. Did tob	oacco use contribute	to the cause of death?
ecoras,	uires Isign									1 ☐ Ye	s 2 No 3	Probably 4X3Unknown
<u>o</u>	A rec	ompleted								24a. Was ar	n 24h Wara	autopsy findings available
Ĕ	has has	mp								autops	y prior	to completion of cause of
-		ပိ								1□ Yes 2		es 2□ No
VItai	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital		-			of Death (	Check only on	θ)	
0	Physic this cral dir	2	1 ☐ Yes 2X No		Inpatient 2		IL SU DOA				ence 6 Other (S	pecify)
	ding P th. After I	on:	27. Manner of Death 1. Maturat 5 □ Pending	28a. Date (Mon	of Injury hth, Day Year)	28b. Time of Injury	Wo			d. Describe ho	w injury occurred	
<u>0</u>	Attending r death.	atl	2 Accident investiga				M 1	Yes 2 N	No			
UNISION	or Atten after deat Director: in by the	ţĮĮ.	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad   289. Place	of Injury - At hing, etc. (Speci	nome, farm, str ify)	eet, factory, office		281	f. Location (Sti City or Town	reet and Number or n, State)	Rural Route Number,
2	spital or Atten ours after deat leral Director: filled in by the	Certification:										
	Hospital 24 hours a Funeral I		29a. Certifier 1 Certifying	Physicien: To the	best of my kn	owledge, death	occurred at the ti	me, date and	d place, and	d due to the ca	ause(s) and manner	as stated.
	To the Hosi within 24 ho To the Func completely f	edlcai	one)	and man	ner stated.	audir ailu/oi i/i	vostigation, in iny (	opinion, deat	00001180	at trie tillie, de	ate and place, and c	ade to tile cause(s)
	To t	Σ	29b. Signature and title of certifier		,		29c. Licens	se number		25	9d. Date signed (Mo	
			Candan	L. Wil.	Sou,	NO		D0061	937		10/12/	05
1	(2)		30. Name and address of person w		se of death (Ite	m 23a) (Type,	Print)					
1	0		CANDACE L. W.	11 SON A	1 65	500 FO	REST LIA	EN RD	,514	VER 5	PRING, N	1) 20910
₩.,	Sta	te	31. Date filed (Month, Day, Year)	2. F	Registrar's Sign	ature	-0		1			
	Registr		OCT 1 7 20	US SE	w &	Spel	le le					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Melvin C. Johnson October q 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Cheverly
If Under 1 Year If Under 24 Hrs. Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X**M 2□F Months Yrs Director 579-18-7774 84 July 28, 1921 Wash., DC Usual Residence of Deceden filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow ir than "neturel", or iteme 23a or 28a-f ahov the Medical Examiner must be nutified at 1 X Yes 2 □ No Maryland Prince George's Direct Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1207 Addison Road 20743 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: **Black** 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Proprietor Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Peges 1 end 2 should be inent of Heelth and Mental int: if item 27 is marked o 2 Unknown Edna Garrett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Saundra J. Smith/Daughter 7062 Hanover Parkway, Greenbelt, MD 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pege Department of important: if any injury or once. 1 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 10/14/2005 Clinton, MD 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Service Licensee/ 4001 Benning Rd., N.E. Wash., DC 20019 Lewar 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Chuse (Final disease or coldition resulting in death) **Physician** Fatal Cardiac Arrythmia /Medical Due to (or as a consequence of) Examiner Hypertension 10 Years Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ed by the attending physicien and detached for use as the burial-transit The law requires that the death certificate be executed Diabetes 10 Years Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown sate hes been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 🔀 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: Certification: To 1 ☐ Yes 2 🙀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e To the Funerei C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 D0029654 J. Wendell on Connell won October 11, 2005 30. New and address of person who completed cause of death (Item 23a) (Type, Print) J. Wendell McConnell, M.D. 1221 Mercantile Lane, Largo, MD 31. Date filed (Month, Day, Year) State OCT 1 7 2005 Registrar

			1 - For State Registrer	State of Ma	ryland / Dep <i>Ce</i>	artment rtificate			Mental H	/giene )	5 35075
	Physici /Medic Examir	cal	4a. Facility Name (II not institution, give	e street and number)	JR Lex	wes	fmin	ation of Dea		Day	exoll
	Funeral Director		5. Social Security Number 76. S 176 32 1499 Usual Residence of Decedent	ex 7. Age ☑ M 2☐ F 8]	(In yrs. last birthday, Yrs.			Under 24 Hrs ours Min		irth 124 (ea <i>r</i> )	9. Birthplace (State or Foreign Country) Pennsylvania
036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It was a read that then "natural", or Itams 23s or 28s-1 show other traumetic avant, the Mardical Examination institution at	by Funeral Director	10a. State 10b. County  MD Carroll  10e. Street and Number  7200 Third Ave.  11. Marital Status  1 □ Never Married 2 ★ Married  3 □ Widowed 4 □ Divorced	, C58  12. Was Decedent E- Armed Forces? 1 Styles 2 DN: 1f Yas, Give Year or Dates: 1	1946-	11e 10f. Zip C 217	84 nt of Hispan y Cuban, Me	nic Origin? (s exican, Puer	Specify Yes or N to Rican, etc.)		10d. Inside City Limits 1 □ Yes 2√√ No  What Country?  ee - American Indian, ck, White, etc.
and 21215-0036	should be filed within 72 ho nd Mental Hygiene. marked other than "natur imetic avant, the Medical	b Be Completed	15. Decedent's Ed (Specify only highest graded) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) John A. Jennings	de completed)  College (1-4or 5+	(Give	dent's Usual e kind of work DO NOT use	done during retired)	g most of wo	me (First, Middl	Westing e, Maiden Suman	
Baltimore, Maryland	permit. Pages 1 and 2 should Department of Health and Men Important: If Itam 27 Is marke any injury or other traumatic once.	To	19a. Informant's Name/Relationship (    Jean Jennings   Wi   20a. Method of Disposition     1	Type, Print)  Fe  Removal from State  ()	7200 20b. Place of Disposemetery, cre St. John	Third Desition (Name matory or other second 2. Name and	Ave, ( of er place) etery Address of	10/1	Sykesvil Date .8/2005 LTTY H.	te, City or Town, le, MD 20c. Location - Ellicot	21784 City or Town, State t City, MD Family FH, Inc
8760,	Physician /Medical Examiner prize prize the prize transit the prize transit the prize transit prize	edical Examiner	23a. Part1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a Due to (or as a c.	LHUMIA consequence of):	ocular the mode of	of dying, sur	Oise ne 2	ese Nuy d		Approximate Interval Between Onset and Death
O. Box 6	The law requires that the death certifics ate has been signed by the attending ph bage 2 should be detached for use as ti	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	⊒Ectopic preg ⊒ Other <i>(spec</i>				23d. Dat Mor	te of delivery nth Day Year
cords, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions o	ontributing to death but	not resulting in the u	inderlying cau	se given in I	Part I.		Yes 2 ☐ No	ribute to the cause of death?  3 Probably 4 Unknown  Were autopsy findings available
of Vital Records,		n; To Be Completed	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death	Hospital: 1 Inpatient	28b. Time o	_	Other		auto perf 1 ☐ Yes ath <i>Check onl</i> Home 5 ☐ Res	ormed?	orior to completion of cause of death? □ Yes 2□ No er (Specify)
Division	To the Hospital or Attanding Physician: within 24 hours after death.  To the Funaral Diractor: After this certific completely filled in by the funeral director.	Certification;	1 Matural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined		y - At home, farm, st	М	1 🗌 Yes	2 No		(Street and Numbe wn, State)	er or Rural Route Number,
	To the Hospital within 24 hours a To the Funaral Completely filled	Medical (	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exemose)  29b. Signature and title of certifier	ysicien: To the best of niner: On the basis of e and manner state	examination and/or in	vestigation, in	the time, da my opinion icense num	i, death occi	e, and due to the urred at the time	date and place, a	and due to the cause(s)  If (Month, Day, Year)
8			30. Name and address of person who		) ath (Item 23a) (Type.	Print)	5107°	2 vister	70	1011	3105
	Sta Registi		31. Date filed (Month, Day, Year)		's Signaturd	barte	VITIO	VISTA	100	X112 1	

		State of M	laryland / Depar	elible Ink. Ensure A rtment of Health and N ificate of Death	Mental Hygien	2005 35076
Physici /Medi	cal	1. Decedent's Name (First, Middle, Last)  H, J, J, G, L, S  4a. Facility Name (If not institution, give street and number,	e Jac	KSON 4b, City, Town, or Location of Death	Reg. N  2. Date of Death Month 4	3. Time of Death  C. Coupty of Death
Examir Funeral Director		9.154/A AMIN'M MEA 5. Social Security Number 6. Sex 1 → 3 2 - 0 2 1 6 1 → M 2 2 F	ge (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day, Yea	Niamica  9. Birthplace (State or Foreign Country)  Maryland
death with the Maryland me 23a or 28a-f show	Director	Usual Residence of Decedent  10a. State 10b. County  MD Talbot  10e. Street and Number		ation 5 + 0 M 10f. Zip Code	10g. C	10d. Inside City Limits 1 (12√es 2 □ No  Citizen of What Country?
ie 2	by Funeral D	201-Federal Street  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Deceden Armed Forces 1 Yes 2 El If Yes, Give Year or Dates:	t Ever in U.S. 13. W	/as Decedent of Hispanic Origin? (Sy Yes, specify Cuban, Mexican, Puerto Yes 20 No Specify:	pecify Yes or No- Prican, etc.)	USA  14. Race - American Indian, Black, White, etc.  Specify: Black
d withir giene.	Completed I	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or	16a. Decede (Give k life. D	ent's Usual Occupation ind of work done during most of work O NOT use retired)  18 Methods No	king	Kind of Business/Industry
Tarylan 2 should be and Mental Is marked or	To Be	17. Father's Name (First, Middle, Last)  Percy ROSS  19a. Informant's Name/Relationship (Type, Print)  EStella Thuma:	7777		Y Wils	O M v or Town, State, Zip Code)
timore, t. Pages 1 an riment of Heal riant: If Item 2		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	20b. Place of Dispos cemetery, crem Richards	ition (Name of	Date 20c.	Location-City or Town, State a Stow, Maryland
Physician /Medical		regulting in death)	ed the ath. Do not enterline.	In Washington	St. Camb	Approximate Interval Between Onset and Death  10 days
be executed be executed ician and purial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter uncerying Cause (Disease or injury that initiated events	is a consequence of):  As a consequence of):  Is a consequence of):	- infection		
Hecords, P.O. Box 68 // The law requires that the death certificate I te has been signed by the attending physions 2 should be detached for use as the I	Physician/Medic		2 Fetal death 3 at time of death 5	Ectopic pregnancy Other (specify)	- in 377	23d. Date of delivery Month Day Year
Cords, P. w requires that i been signed by should be deta	þ	Part II. Other significant conditions contributing to death	lar "	derlying cause given in Part I.	1 ☐ Yes	to use contribute to the cause of death?
	Be Completed	25. Was case referred to medical examiner?		26. Place of Dec	24a. Was an autopsy performed 1 Yes 2	
on of ling Phys After this funeral di	Certification; To E	1 Yes 2 No Hospital: 1 Hipa  27. Manner of Death  28a. Date of Ir (Month, L	njury 28b. Time of Injury	28c. Injury at Work? M 1 \( \text{Yes} \) 2 \( \text{No} \) No	28d. Describe how in	
Division of To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral		4 Homicide determined 288. Place of building,	Injury · At home, farm, streetc. (Specify) st of my knowledge, death	occurred at the time, date and place	City or Town, St	a(s) and manner as stated.
To the Hc within 24 I To the Fu completely	Medical	(Check only 2 Medical Examiner: On the basis and manner  29b. Signature and title of certifier	stated.	29c. License number	29d.	Date signed (Month, Day, Year)
9	tate		of death (Item 23a) (Type, Item 23a) (Type, Item 23a) (Type, Item 23a) (Type, Item 23a)	Peninsula Regio	nal Medical	Center Salisburgy Maryland
Regis		001 17 2003	energy BR	ghangs.		

			Registrar	State of Maryla	and / Dep <i>Ce</i>	artment of H ertificate of L	lealth and M Death	Re	g. No.	35077
	Physicia	an	Decedent's Name (First, Middle, Last)  JAMES	DOUGLAS	1	KELLY		2. Date of Death Month October	Day Year	3. Time of Death  9:00 p M
	/Medic Examin		4a. Facility Name (If not institution, give st				Location of Death	OCCODEL	4c. County of Death	
			Brighton Gardens a	t Tuckerman	Lane	Rockvi	11e		Montgomer	v
	Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		rs. last birthday		If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day, April 10	Year) 9. Birth	place (State or Foreign intry) MO
	and and	}	Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits
	Mary F sho	to	MD Montgome	ery R	Rockvil]	le				1 Yes 2 No
	with the 3a or 28e	i Direc	10e. Street and Number 5550 Tuckerman Lan	ne #234		10f. Zip Code		10	Og. Citizen of What Cou	intry?
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If tiem 27 is marked other than "neturel", or Items 23a or 28e-f show or other treumetic event. Its Medical Evaria or Invat Le ricities and	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces?  1 Tree 2 No If Yes, Give Year or Dates: 194		Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Whi	, etc.
Maryland 21215-0036	hin 72 ho a. "netur Medicul	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Giv	edent's Usual Occupa e kind of work done of DO NOT use retired	during most of worki	ing	16b. Kind of Business/li	ndustry
21	filed wit Hygiene other the		12	4	Of	fficer	40 Markada Mara	(Fine 44:44) A	U.S. Air I	orce
and	d be fill he double of other	Be c	17. Father's Name (First, Middle, Last)				18. Mother's Name		raiden Sumame)	
Ž	should I	ဥ	James W. Kellv  19a. Informant's Name/Relationship (Typ)	θ, Print)	19b. Mail	ling Address (Street a	Ada Doug	glas al Route Number,	City or Town, State, Zi	p Code)
Ma	alth ar 27 is		Helen M. Kelly/daug	hter-in-la	1323	Hiddenbro	ook Dr	Herndon	. VA 2017	0
ore,	of He of He it item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re		o. Place of Disp cemetery, cre	position (Name of ematory or other place	(e)	Date 2	20c. Location - City or T	own, State
Baltimore,	Pag tment tent: I		' 4 ☐ Donation 5 ☐ Other (Specify)	A		on Nationa		14, 2005	Arlingt	
Bal	permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 is eny injury or other treu 906e.		21. Signature of Funeral Service License	ans	2	22. Name and Addres	PM.		en Funeral Herndon,	
	Fnysician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	ations that caused the decause on each line.  Due to or as a cons	ance				ist,	Approximate Interval Between Onset and Death
68760, <	ecuted and -transit	al Examiner	Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons						
687	uficate g phys as the	edical	d.		-				7,170	-
.O. Box	requires that the death cert een signed by the attending hould be detached for use a	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of delive Month	rery Day Year
Δ.	w requires that been signed b should be deta	ed by Pl	Part II. Other significant conditions conf	ributing to death but not	resulting in the	underlying cause give	en in Part I.		accoluse contribute to	2.6
al Records,	The law ate has b page 2 sl	Completed						24a. Was ar autopsy perform 1 \( \text{Yes} \) 2	y prior to co	opsy findings available ompletion of cause of
Vital	ysicien: Th is certificate director, pag	Be c	25. Was case referred to medical examiner?	ospital:		ont 3 DOA Othe	26. Place of Death			
Division of	ding Ph h. After th funeral	tion: To	1 Yes 2 XNo 1  27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year	2 ER/Outpatie 28b. Time Injury	of 28c. Injun	v at	me 5 Neside 28d. scribe ho	nce 6 Other (Speci w injury occurred	(fy)
Divisi	i gete	Certification;	3 Suicide 6 Could not be determined	28e. Płace of Injury - A building, etc. (Spe	at home, farm, s ecify)	street, factory, office		28f. Location (Str City or Town	reet and Number or Rui , State)	al Route Number,
	ne Hospitel n 24 hours e ne Funerel l	Medical C		ician: To the best of my er: On the basis of exam and manner stated.						
)	To the P within 2: To the I complet	W	29b. Signature and Hillard carliffes	2-		29c. Licenso	1 12 18	29	od. Date signed (Month)	Day, Year)
	15		30. Name and address of person who cor	inpleted cause of death (	Item 23a) (Type	Print) 135	55 P.C	Carr	Dr. 20'85	70
	Sta Registi		31. Date filed (Month, Gay, Year)	32. Registrar's Si	gnature	And i				
				APP	-					

State of Maryland / Department of Health and Mental Hygiene 0 0 5 Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) October 22, 2005 **Physician** 0500 Ralph Thomas King /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick 410 Biggs Avenue Frederick Months Days Hours Min. June 10, Year 1918 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1√2 M 2 □ F Months Virginia 87 Yrs. **Director** Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County an "naturel", or items 23a or 28e-f show Medical Examinatings must be notified at Frederick Frederick Maryland 1y□Yes 2□No by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21702 U.S.A. 410 Biggs Avenue 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1√DYes 2 □ No IfYes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene Important: If item 27 is marked other than "naturel", or item any injury or other treumatic event, the Medical Examina 1 Never Married 27 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Heavey equipment operator Execavating Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Daisey Albert Daniel John William King 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 410 Biggs Avenue, Frederick, Maryland 21702 Rachel S. King/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Resthaven Memorial Gardens Oct. 26, 2005 Frederick, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney and Basford Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause of each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) YEAR **Physician** UNG CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): Box 68760, attending physician Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, OBSTRUCTIVE PULLONARY DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2. No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Fresidence 6 Other (Specify) 1 ☐ Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of the Hospitel or Attending 5 Pending investigation 1 Z Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after of Funerel Direct 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier october D10587 25 Jeng HOSPICE OF PRIDICK COUNTY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HEDICAL DIRECTOR FREDERICK STE TRAK 1. ShITH State 2005 Registrar

			State of Maryland / De	partment of Health and Mer ertificate of Death	
2	Physici /Medic	_	Decedent's Name (First, Middle, Last)     Beulah Jean K		Date of Death Month Day Year  O-25-65  3. Time of Death
	Examir Funeral Director	_	4a. Facility Name (If not institution, give street and number)  Carroll Hospital Center  5. Social Security Number 6. Sex 7. Age (In yrs. last birthd)  220-20-5814 78 Yrs	4b. City, Town, or Location of Death  Westminster  By If Under 1 Year   If Under 24 Hrs.   8, Months   Days   Hours   Min.   M.	4c. County of Death  Carroll County  Date of Birth (Month, Day, Year)  ar. 23, 1927 Maryland
	D	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or		10d. Inside City Limits 1X Yes 2 □ No
	h with the	al Direc	10e. Street and Number 7309 Second Avenue	10f. Zip Code 21784	10g. Citizen of What Country? United States
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show important; or other traumatic event, the Modical Examiliar could be reciliated at once.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 MDivorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	<ol> <li>Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rican 1 ☐ Yes 2X No Specify:</li> </ol>	Yes or No- an, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
Maryland 21215-0036	d within 72 ho piene. r than "natu ine Modical	ompleted	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of working b. DO NOT use retired) nemaker	own home
/land	should be filed nd Mental Hyg marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Last) Ralph LeMaster	18. Mother's Name (Fi Maude Nor	rst, Middle, Maiden Sumame) a. Hodge
	and 2 sho eaith and ! n 27 is me		John E. King / son 888		n Bridge, Maryland 21791
Baltimore,	permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, Ins. M. ODG.			position (Name of rematory or other place)  urg Crematorium  22. Name and Address of Facility	26 Smithsburg, Maryland
Ba	permit. Departr Imports any inju			136 East Baltimore St	
68760, <	The law requires that the death certificate be executed with the death certificate be executed at the last been signed by the attending physician and with the last beautiful be detached for use as the burial-transit	edical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in flur) that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	'S ( S	Onset and Death
O. Box	that the death certif ned by the attending detached for use a	Physician/Med		3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery Month Day Year
rds, P.	w requires that been signed be should be det	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e, Did tobacco use contribute to the cause of death?  1 □ Yes 2 XNo 3 □ Probably 4 □ Unknown
al Records,	n: The law requ ficate has been n, page 2 should	Completed			24a. Was an autopsy performed?  1□ Yes 2√No   24b. Were autopsy findings available prior to completion of cause of death?  1□ Yes 2□ No
of Vital	g Physician: er this certifica ieral director, p	n; To Be	25. Was case referred to medical examiner?  1  Yes 2 No  1 Inpatient 2 ER/Outpa  27. Manner of Death 1 Natural 5 Pending (Month, Day Year) Injury	of 28c. Injury at 28d.	5 Residence 6 Other (Specify)  Describe how injury occurred
Division	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	1 Natural 5 Pending (Montn, Day Year) Injur 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	M 1 Yes 2 No	Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, did not be the composition of examination and/or and manner stated.	eath occurred at the time, date and place, and investigation, in my opinion, death occurred a	due to the cause(s) and manner as stated. It the time, date and place, and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number D 30263	29d. Date signed (Month, Day, Year) October 25, 2005
	Ì		30. Name and address of person who completed cause of death (Item 23a) (Typer Prancis (FROLL HOSP)  31. Date filed (Month, Day, Year)  32. Ragistrar's Signature	De, Print) OENTER, ZOO M	EMORIAL AVENUE MINSTER, MD 21157
DH	Sta Regist MH 17 Rev 1/2	rar	OCT 3 1 2005	field -	·
			ORIGII	NAL	

			1- State of Maryland / Depa Registrar Cent	rtment of Health and M tificate of Death	ental Hygie	2000	35080
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Van	3. Time of Death
	Physici /Medic		William George Kemp		October	21 2005	1015 A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	h
			135 Kemp Lane	E1kton		Cecil	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y July 12, 1	(ear) 9. Birt	hplace (State or Foreign untry)
	Director		217-03-8113		July 12, 1	1919 Ma	arýland
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc	ation		-	10d Incide City Limits
	aho a al	5		ALCO I			10d. Inside City Limits 1   Yes 2   No
	28a-f	Director	Maryland Cecil Elkton  10e. Street and Number	140/ T. O. /	1.12	000	
	with t			10f. Zip Code	109	. Citizen of What Co	
	s 23	era	135 Kemp Lane 11. Marital Status 12. Was Decedent Ever in U.S. 13. W	21921 Vas Decedent of Hispanic Origin? (Spe	aif. Vac ar Na	United St	
	ter d	Funeral	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 No Married 1 No Yes 2 No	Yes, specify Cuban, Mexican, Puerto I	Rican, etc.)	Black, White	
99	al', or	by	3 ☐ Widowed 4 ☐ Divorced   If Yes, Give   War II   1	☐ Yes 2 No Specify:		Specify: Wh	ite
21215-0036	2 hou	Completed	15. Decedent's Education 16a. Decede	ent's Usual Occupation	16	b. Kind of Business/	
75	hin 7	ple	(Specify only highest grade completed) (Give kife. D	ind of work done during most of workir O NOT use retired)	ng		
2	d wit giene grathe	Ю		orney		_ Law	
P	al Hy al Hy foth	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma.	iden Sumame)	
Maryland	Ments Ments arka attc	To	William G. Kemp	Mary Ja	ane Klaus	man	
an	2 sho and la ma			Address (Street and Number or Rura		•	
	and ealth n 27 ner tr			ast Main Street, I			
Baltimore,	perruit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertunent of Health and Mental Hygiene. In Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show supprintury or other traumatic event, the Medical Exeminar motal be notified at anone.		20a. Method of Disposition  1 ABurial 2 Cremation 3 Removal from State  20b. Place of Dispos  Complete, Cerm	ition (Name of atory or other place) Octob	er 27,	c. Location - City or	Town, State
<u>Ē</u>	Pag ment ant: ury c		'4 Donation 5 Other (Specify) Memorial	Park 2005	5 E	lkton, Ma	rvland
a a	perrait. Depart Import any Inj pace.		21. Signatore of Funeral Service Licensee	Name and Address of Facility CKS Home for Fune	rals. P.	Α.	
<u>-</u>	205 2		Donald S. Hules 10	3 W. Stockton Str	eet, Elk	ton, Maryl	and 21921
			23a. Part1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.	r the mode of dying, such as cardiac of	r respiratory arrest		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Cardiomyon	thy		Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequent of):	Cardiomyope	/		100
	Examino.	L	Sequentially list conditions, b. That Fibyil	lation	- 16-		OVV
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	and and al-trar	xan	that initiated events c				
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×	The law requires that the death certifi tle has been signed by the attending bage 2 should be detached for use a	N.	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deli	verv
Вох	death a atte	clai	in the past 12 months?  1 Ves 2 No.  4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		Month	Day Year
0	the cy the ache	hys	9 ☐ Unknown				
O.	res that igned b	by Physician/M	Part II. Dther significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Records,	w require been sig should b	edt	Vementia		1 ☐ Yes	2 □ No 3 □ Pro	bably 4 Unknown
00	s been s been s should	plet			24a. Was an	24b. Were au	opsy findings available
æ	The lay te has age 2	Completed			autopsy performed	death?	ompletion of cause of
Vital	ician: Th	Bec	25. Was case referred to medical	26. Place of Death	(Check only one)	100 10 105	2 140
	Physician: this certificanal director.	0	examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient	Othor		e 6 □Other (Spec	ifv)
οl	ding Physician: The la h. After this certificate has funeral director, page 2	L iu	27. Manner of Death 28a. Date of Injury 28b. Time of (Month, Day Year) Injury		8d. Describe how		.,,
jo	Attanding or death. ector: After by the fune	atlo	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division	er de recto	tifle	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office 2	8f. Location (Stree City or Town, S	t and Number or Rus	ral Route Number,
	ital o	Certification:			,	,	
	a Hospital or Attand 24 hours after death Funaral Director: etely filled in by the	edical	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or invegence.	occurred at the time, date and place, a	nd due to the caus	e(s) and manner as	stated.
	To the Hospital or Attandi within 24 hours after death. To the Funaral Director: A completely filled in by the tr	Medi	and manner stated.				
	To Con	~	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	, Uay, Year)
•	1		Dalbara A /arey mo	1025915		10 21	05
	2x1		30. whe and address of person who complete chuse of death (light 23a) (Type, P		Па.	14	
	7		Barbara A. Parey, M.D., 111 West High  31. Date filed (Month, Day, Year)  32. Registrar's Signature	Street, Suite 214	Likton	, Maryland	1 21921
	Sta Registr	-	ANT 9 8 2005 Persons A				

		1 - For State Registrar	State of Maryla			of Health and of Death		ene . N2 0 0 5	35081
Physic	ian	1. Decedent's Name (First, Middle, Last) Ruth Elizabeth KEI	TV				2. Date of Death Month	Day Year	3. Time of Death
/Med Exami		4a. Facility Name (If not institution, give st			4b. City, To	own, or Location of Dea	October	4c. County of De	
Exam.		Washington County	Hospital			rstown		Wash	ington
Funera Director		5. Social Security Number 6. Sex 1 C	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Months D	Year If Under 24 Hr Days Hours Min	. (Month, Day,		irthplace (State or Foreign Country)
		Usual Residence of Decedent					April 14	, 1919 F	Pennsylvania
Aarylar Febow	ō	10a. State		ity, Town or Lo		torm			10d. Inside City Limits 1 2 Yes 2 □ No
r 28a-i	Director	10e. Sireel and Number	.011	-	Hagers 10f. Zip Co		10	g. Citizen of What C	
ath witi	ralD	207 Pangborn Boule	evard			21740		USA	
ter dex	Funeral	11. Marital Status 1:  1 Never Married 2 Married	<ol> <li>Was Decedent Ever in the Armed Forces?</li> <li>1 ☐ Yes 2 ☑ No</li> </ol>	U.S. 13.	Was Deceden II Yes, specify	nt ol Hispanic Origin? ( Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Wh	erican Indian, ite, etc.
ified within 72 hours after death with the Maryland Hygiene.  Hygiene.  And a start of teme 23a or 28a-1 show any, the Medical Exaction of the Medical	þ	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:		1⊡Yes 2⊠	No Specify:		Specify:	white
natu	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual ( kind of work of DO NOT use	done during most of w	orking 1	6b. Kind of Busines	s/Industry
y withir jiene. r than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		emaker	reurea)		her own h	nome
be filed tal Hyg d othe	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle, M	aiden Sumame)	
hould I warke	2	Willis Lehman  19a. Informant's Name/Relationship (Typ)	e Print)	10h Mailir	Addross /S	Molly Street and Number or F	V. Moats	City on Town Con-	Ti- Co-day
nd 2 s alth an 27 ie i		Michael Kelly - so				le Cedar C			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show any Injury or other treumatic event, the Medical Examinant has notified at any other treumatic event.		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Re	20b.	Place of Dispo cemetery, crer				Oc. Location - City o	
it. Pag intenti intent:	- The state of the	4 Donation 5 Other (Specify) 21. Signature of Surreral Service License	Re	est Hav					n, Maryland
Depariment of the particular o		TO THE STATE OF THE LICENSE	Munice			Wilson B1	INNICH FUN		
7 gr gg 197		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the dea	ath. Do not ent	er the mode o	of dying, such as cardia	ac or respiratory arres	st,	Approximate Interval Between
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	chron	ic c	obstru	least	rng D	ise ask	Onset and Death
Examiner			Due to (or as a conse	quence of):	- н	eart	Failure		
p H	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a conse						
sxecute and al-trans	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conse	quence of):					
ite be e ysiciar ne buri	icai E	d.							
ertifica ling ph e as th		IF FEMALE:							
attend aftend for us	cian/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 100	<ul> <li>c. If yes, outcome of pregr</li> <li>1 Live birth 2 Fet</li> <li>4 Pregnant at time of</li> </ul>	al death 3	Ectopic pregi			23d. Date of de Month	elivery Day Year
at the c by the	Physician/Med	9 Unknown	9□ Unknown						
signed de de	þ	Part II. Other significant conditions cont	nbuting to death but not re	sulting in the u	nderlying caus	se given in Part I.			to the cause of death?
w requ	jetec						24a. Was an		robably 4 Unknown
The la	Completed						autopsy performe	prior to death?	completion of cause of
VII.a Ician: Sertifica ector,	Be	25. Was case referred to medical examiner?	and di	-			eath (Check only one		
Phys or this	1.70	1 Yes 2 No	28a. Date of Injury (Month, Day Year)	ER/Outpatier		<del></del>	Home 5 Residen		ecify)
ath.	ation	1. ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	М	. Injury at Work? 1 ☐ Yes 2 ☐ No		,,	
or Attendented Director in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, sir	eet, factory, o	office	28f. Location (Stre City or Town,	eet and Number or F State)	Rural Route Number,
To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1— Certifying Physical Examin	cian: To the best of my kn	owledge, deatl	n occurred at	the time, date and place	e, and due to the cau	use(s) and manner a	s stated.
the H thin 24 the F mplete	Medical	29b. Signature and title of certifier	er: On the basis of examin and manner stated.	and/or in		i my opinion, death occ		e and place, and du  d. Date signed (Mon	
¥ 50 8		Jan m	Much			60396	290	10/17/	05
		30. Name and address of person who con		em 23a) (Type,	Print) )	26 ope	1,ct	-	1 1 0
6H-3	tate		M SHED  32. Degistrar's Sign	nature	4	Hyx	rstiwn	wy 5)	140
Regis		31. Date filed (Month, Day, Year) OCT 18 200	5 Deser	B. Sp	whi				

		For State Registrar	State of Ma		epartment of I			2005	35082
Physicia /Medic Examin	al	Decedent's Name (First, Middle,     A. Facility Name (If not institution,	MAR	IE	4b. City, Town, o	LLY or Location of Death	2. Date of Death Month	Day Year 13 2005 4c. County of Death	3. Time of Death
Funeral			6. Sex 7. Age	e (In yrs. last birth	Months Days		8. Date of Birth (Month, Day, Y	Howard (ear) 9. Birth	place (State or Foreign
Director		209         18         0502           Usual Residence of Decedent           10a. State         10b. County	7 ZESF 7	10c. City, Town	'S.		Sept 22,	1927 Per	nnsylvania  10d. Inside City Limits
the Mary 28e-f sho	Funeral Director	MD Howard  10e. Street and Number	đ	Columbi	.a. 10f. Zip Code		100	g. Citizen of What Cou	1 □ Yes 2 X No
h with 23a of	ai Di	6636 Cedar Lane			21	044		United St	ates
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mentall Hygiene. Department of Heatin and Mentall Hygiene. Department: If them 27 is marked other than "natural", or items 23a or 28e-f show eny injury or other treumatic event, the Medical Examinar must be notified at once.	by Funer	11. Marital Status  1 □ Never Married 2 □ Marrie 3 □ Widowed 4√ □ Divorced	12. Was Decedent I Armed Forces?  1  Yes 2 N If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No		ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
72 hou	ted	15. Decedent' (Specify only highest		16a. C	Decedent's Usual Occup	pation	16	bb. Kind of Business/In	idustry
ed within ygiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	)+)	Give kind of work done life. DO NOT use retire Homemaker			Own Home	
y carry ould be fill Mental Hi tarked oth	To Be	17. Father's Name (First, Middle, L Edward Hoban				18. Mother's Name Helen Eag	gan	,	
d 2 sh d 2 sh th and 7 ls m treum		19a. Informant's Name/Relationsh  Jean M. Kelly/D			Mailing Address (Street				
Pages 1 and nent of Health int: If Item 27 inty or other tr		20a. Method of Disposition  Burial 2 ☐ Cremation	3 □Removal from State	20b. Place of L cemetery,	6 Poland S Disposition (Name of crematory or other pla	сө)	Date 20	c. Location - City or To	own, State
nit. Parantmer ortant injury		<ul> <li>4 □Donation 5 □ Other (Sp</li> <li>21. Signature of Funeral Service L</li> </ul>		M01044	Lawn Mem.				lle, MD lly FH Inc.
Departition Department in procession of the proc		Rem Gl	Ins- With	L	THE RESERVE OF THE PARTY OF THE			cott City,	The same of the sa
Physician /Medical Examiner	Examiner	23a. Part. Enter the disease, or shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. Due to (or as	a consequence of	obstru	ng, such as cardiac c	or respiratory arres		Approximate Interval Between Onset and Death
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dicai	that initiated events resulting in death) Last	c.  Due to (or as a	a consequence of	):				
ires that the death certifications by the attending phe detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnance 5 ☐ Other (specify)	у		23d. Date of delive Month	ery Day Year
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ician: The law requirection: The law requirections been rector, page 2 should	Completed						24a. Was an autopsy performe	prior to co	opsy findings available impletion of cause of
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tal or Atters atters at Director	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		ury - At home, farn c. <i>(Specify)</i>	n, street, factory, office		28f. Location (Stree City or Town, S	et and Number or Rura State)	ıl Route Number,
the Hospi iin 24 hour the Funer	Medicai		g Physician: To the best of Examiner: On the basis of and manner sta	f examination and/	or investigation, in my o	ppinion, death occurr			
To T	2	29b. Signature and title of certifier	AD: 61	) NA	29c. Licens	se number	290	I. Date signed (Month,	Day, Year)
		30. Name and address of person v	who completed cause of d	eath (Item 23a) (T	ype, Print)	4001	421	V 1 1 1.	> 2005
E.G.		1082	0 Hick	cory	Ridge	Road	Cotu	MbigM	D21044
Sta Registr		31. Date filed (Month, Day, Year)  OCT 17		ar's Signature	Courte		•	•	. ,

Jeseph A. Lyddane Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

		Please 1					nk. Ensure A of Health and I	-		_	
		1 - Stata Registrar	Otate of Wil	aryland			of Death	-	Reg. No.	And the same	35084
Physici /Medie		Decedent's Name (First, Middle, Last     JOSEPH ALTON LYDD	,					2. Date of De Month OCTOBER	Day	Year 2005	3. Time of Death
Examir		4a. Facility Name (If not institution, give				4b. City, To	wn, or Location of Death		-	County of Death	0.00 1-17
Funeral		CIVISTA MEDICAL ( 5. Sociat Security Number 6. Se	7. Ag	e (In yrs. la:	st birthday)	If Under 1 Y				HARLES 9. Births	lace (State or Foreign
Director		224-22-2093 1E	<b>X</b> M 2□ F	82	Yrs.	Months D	Days Hours Min.	JUNE 22	2, 19	923 WASH	INGTON DC
yland how		10a. State 10b. County		10c. City,	Town or Lo	ocation				1	0d. Inside City Limits
the Ma 28a-f	Director	MARYLAND CHARLES				10f. Zip Co	ALDORF		10a Citi	zen of What Cour	1 Tyes 2 No
urs after death with the Marylan urs afterne 23a or 28a-f ehow Espriner must be notified at	ai Dir	1103 FALMOUTH ROA	D			101. 2.0	20601			NITED ST	
er dea	Funeral	11. Maritat Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 DYes 2 0	101	. 13. Y	Was Deceden If Yes, specify	nt of Hispanic Origin? (S Cuban, Mexican, Puerl	pecify Yes or No to Rican, etc.)	)-	14. Race - Americ Black, White,	
	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	194	-	1 □ Yes <b>X</b> 12	No Specify:			Specify:	vhite
n 72 ha	Completed	15. Decedent's Edi (Specify only highest grad	le completed)		(Give	dent's Usual C kind of work of DO NOT use i	done during most of wor	rking	16b. Ki	nd of Business/In	dustry
d withi	Somp	Elementary/Secondary (0-12)	Cotlege (1-4or !	5+)			PRINTER			IBM	
ntal Hy	Be	JOSEPH R. LYDDANE						me <i>(First, Middl</i> e, I MARSHAL		Sumame)	
s 1 and 2 should be filed within 72 h if Health and Mental Hygiene. Item 27 is marked other then "netur other traumatic event, its Medical	To	19a. Informant's Name/Relationship (T)	ype, Print)		19b. Mailir	ng Address (S	Street and Number or Ru			r Town, State, Zip	Code)
1 and 2 Health and 27 is		JOSEPH M. LYDDANE 20a. Method of Disposition	- SON			FALMOUT	TH RD., WAL			AND 2060:	
permit. Pages 1 Department of the important: if ite ony injury or ot once.		1		Cer	metery, crei	matory or other	er place) UCI.	•		TOBACC	
permit. F Departm Importa- eny injui		21. Signature of Fundal Service Licens	800		22	2. Name and A	Address of Facility				20604
3 80558		23a. Part1. Enter the disease, or comp	MO1				JNERAL HOME			6, WALDO	Approximate
Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Acute  Due to (or as	M	7070 Ince of):	urdi	id Infe	arch	in		Interval Between Onset and Death
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cate be chysicient the bu	ledical		d.								
Heath certificate be attending physic for use as the b	cian/Me	23b. was decedent pregnant	23c. If yes, outcome 1⊟Live birth			Dectopic pregi	nancy		2	23d. Date of delive	,
he dea / the att	Physici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Preg <i>n</i> ant a 9□Unknown			Other (speci				Month	Day Year
res that the de signed by the a	by Ph	Part II. Other significant conditions co	ntributing to death b	out not result	ting in the u	inderlying caus	se given in Part I.	23e. Did t	obacco u	ise contribute to th	ne cause of death?
w require been sig should b								10'		XNo 3□Prob	
B & & C1	Completed							24a. Was autoj perfo		prior to co death?	psy findings available mpletion of cause of
ysicien: The l is certificate ha director, page	Be	25. Was case referred to medical examiner?	Hospital:				1 -	ath (Check only o			
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f or Attending I after death. Director: After in by the funer	catio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Da		Injury	М	Work? 1 ☐ Yes 2 ☐ No				
To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the tuneral	Certification:	4 Homicide determined	289. Place of the	ury - At hon c, (Specify)	ne, farm, sti	reet, factory, o	office	28f. Location ( City or To		d Number or Rura )	f Route Number,
To the Hospitel or within 24 hours afte for the Funerei Dirt completely filled in I	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ysician: To the best iner: On the basis of and manner st	f examination	rledge, deat on and/or in	h occurred at investigation, in	the time, date and place my opinion, death occu	e, and due to the urred at the time,	cause(s) date and	and manner as s I place, and due to	ated. the cause(s)
To the To the comple	Me	29b. Signature and title of certifier				29c. L	icense number		29d. Dat	e signed (Month,	
· ·			Math		\ -		D-52289			10 /13/0	S
DB 6:1		30. Name and address of person who c	10 SATNT				UITE 404 WA	ALDORF 1	MARYI	LAND 206	73
St Regist	ate rar	31. Date filed (Month, Day Year)	32. Figist	ar's Signatu	ıre	backs					

State of Maryland / Department of Health and Mental Hygiene 0 0 5 35085 1 - Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** <sup>□</sup>13,2005 October 5:30 A M Minnie Bella Layfield /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SALISBURY REHAB & NURSING CENTER SALISBURY, MD. 21804 WICOMICO If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Hours 1 □ M 2**X**□ F Yrs. Director 11/14/1923 251-32-6555 Georgetown, Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c, City, Town or Location 10b. County 10d. Inside City Limits 27 is marked othar than "natural", or itams 23a or 28a-f show traumatic avant, the Modical Experiment mustice notified at Director 1 ☐ Yes 2 X No Maryland Wicomico <u>Salis</u>bury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 32329 Sperrin Rd USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify. 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 Administrator Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be and Mental 2 n/a n/a 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Willard Layfield/husband 32329 Sperrin Rd. Salisbury, MD 21804 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

■ Burial 2 Cremation 3 Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Union Church Cemetery 10/17/05 Salisbury, Maryland 22. Name and Address of Facility
Holloway Funeral Home, P.A. 21. Signature of Funeral Sarvice Licenses 501 Snowhill Rd. Salisbury, MD 21804 23a. Part1. Enter the disease, or complications trate cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ? cun a disease or condition resulting in death) /Medical Due to (or as a sonsequence of): **Examiner** 2 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed ding physician and ase as the burial-transit that initiated events resulting in death) Last Due to (or s sequence of) Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed? certificate 2 4 No 1 Yes or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Zursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No I Diractor: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To tha Funaral L 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM ROBINS, M.D. 200 CIVIC AVE., SALISBURY, MD. 21804 32 Registrar's Signature State Siever Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

LAYFIELD

MINNIE

Box 68760,

P.O.

Division of Vital Records,

				For State Registrar	State	e of Marylan		nent of He			giene () (	)5	350	86
	F	Physici	an	Decedent's Name (First, Mid		JOSEPH	Т.	ANGE		2. Date of De. Month	Day	Year 200	3. Time of	
	300	/Medic Examir		ROBERT  4a. Facility Name (If not institut.				City, Town, or L		001000	4c. County		, , , , ,	
		Zamin		Upper Chesa					el Air			Hari		
		Funeral Director		5. Social Security Number 332–14–4101	6. Sex 1 M 2 □	7. Age (In yrs.	Mo		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 5/5/1	y, Year) 917	Cou	elace (State on htry) Llino:	
		land ow		Usual Residence of Decedent  10a. State 10b. Coun	ty	10c. Cit	y, Town or Location	on				1	0d. Inside Ci	ty Limits
		the Marylar 28a-f show notified at	tor	MD.	Harford				Fallsto	n			1 🗆 Yes	2 <b>X</b> No
		ith the	Director	10e. Street and Number			1	Of. Zip Code			10g. Citizen of		-	
		23a		2935 Char.		eet Decedent Ever in U	C 13 Was		21047	ofy Yes or No	Unite	e - Americ		
00	36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28s-1 show or other treumatic event. The Medical Exacult	by Funeral	11. Marital Status  1 □ Never Married 2 M/M  3 □ Widowed 4 □ Divorc	Arme arried 1 1 Yes	d Forces?  (es 2 No s, Give 193  or Dates:		_	panic Origin? (Spe Mexican, Puerto f Specify:	Rican, etc.)	Bla Specif	ck, White,		
2200	Maryland 21215-0036	72 hours "natural", solical Exe	Be Completed b	15. Deced	ent's Education nest grade comple	or batos.	16a. Decedent's	s Usual Occupation of work done during the NOT use retired	on ring most of working	ng	16b. Kind of B			
	121	within and and and and and and and and and an	dmo	Elementary/Secondary (0-12	) Colle	ge (1-4or 5+)			mblyman		A	ire	aft	
	9	illed Hygi other	e C	17. Father's Name (First, Midd	e, Last)				8. Mother's Name					
	/lar	uld be Venta Irked Itic ev	To B	Jos	eph		Lange		Jessi				larve	
5	Man	nd 2 should be filed within 3 aith and Mental Hygiene. 27 ie marked other then " r treumatic event, Ing Med		19a. Informant's Name/Relation Philip A. Li					d Number or Rura d Drive		er, City or Town rest H			050
3/6	ore,	es 1 and 2 of Health I item 27 ir other tre		20a. Method of Disposition 1X Burial 2 ☐ Crematio	o 3 DRemoval f	20b. I	Place of Disposition cometery, cremato	n (Name of ry or other place)	D	ate	20c. Location	- City or To	own, State	
0/23/05	altimore,	Pa ant: ury		4 ☐ Donation 5 ☐ Other	(Specify)	) Be	l Air M							
5	Ball	permit Depart Import any in		21. Signature of Funeral Servi	ce Licensee	Kut		me and Address	00		sville			
		*	11	23a. Part1. Enter the disease, shock, or heart failure. L	or complications t	hat caused the dea			tz & SC			rome	Approximat	е
		Physician		Immediate Cause (Final									Interval Bet Onset and I	ween Death
		/Medical	10	disease or condition resulting in death)		e to (or as a conse			1					N
~	П	Examiner	i.	Sequentially list conditions.		MOCar		intono	ition				10/14	105
3	V	ed	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹ Du	e to ()r as a consec	quence of :		Africe	+			10/2	105
10353	~	be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last	c. Du	e to (or as a conse	quence of):	SULC I	V( 1 W(C	- 1			10/1	103
#	8760,	ate be e hysicien the buria			d									
	9		Physician/Medical	IF FEMALE:					12/72					
	Вох	eath certific attending pl for use as I	lan/	23b. Was decedent pregnant in the past 12 months?	1 🗆 t	s, outcome of pregn Live birth 2 ☐ Fet Pregnant at time of	al death 3 ☐ Ect	opic pregnancy her (specify)				ate of deliv		Year
8	0	that the de ed by the a detached t	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Jnknown	304(ii 3 0ti	nei (specily)						
osep	Г	s that if ned by e detac	by Pr	Part II. Other significant conc	itions contributing	to death but not re	sulting in the under	tying cause given	in Part I.	23e. Did t	tobacco use con	tribute to t	he cause of c	leath?
10	Records,	w requires been sign should be	ed b	renal -	railur	e				1 🗆 '	Yes 2 □ No	3 Pro	oably 4 □l	Jnknown
1.3	ecc	e law re has be	Completed	urinary	+ra	ct iv	tect	Noi		24a. Was	an 24b.	Were auto	psy findings impletion of c	available ause of
te			Con	demer	Itia					1 Yes	2 No	death? 1  Yes	2 🗆 No	
Robert	Vital	Physicien: Tribis certifical	Be C	25. Tas case referred to med examiner?	Hospital:		15D/0	Other	26. Place of Death			has (C	6.1	
3	o	Phys arthis araldi	1: To	1 Yes 2 No 27. Manner of Death		1 atient 2 Date of Injury (Month, Day Year)	28b. Time of	28c. Injury a	4 La real sing rior		how injury occu		y)	
,	ion	Attending Ph r death. ector: After th by the funeral	ation	1 ☑ Natural 5 ☐ Per 2 ☐ Accident inve	ding stigation	(Month, Day Year)	Injury		es 2 No					
ઇ	Division		Certification:		ald not be ermined 28e. I	Place of Injury - At I building, etc. (Spec	nome, farm, street,	factory, office		28f. Location ( City or To	Street and Num wn, State)	ber or Rur	al Route Nurr	iber,
ange	Δ	Hospitel or A 24 hours after Funerel Direktely filled in by	Cer											
77		TAT 0	edicai	29a. Certifier 1 Certifier (Check only 2 Media	al Examiner: On	To the best of my kn the basis of examin manner stated.	owledge, death oc ation and/or invest	curred at the time igation, in my opii	nion, death occurr	and due to the ed at the time,	date and place,	anner as s , and due t	tated. o the cause(s	;)
	-	To the within 2 To the comple	Me	29b. Signature and title of cert	ifier			29c. License	number		29d. Date signe	ed (Month,	Day, Year)	
				ann	Dr 2	Del	- Zu	BD93	308190		actober	r 2	4 2	2005
•	-	IH		30. Name and address of pers	on who completed	cause of death (Ite	m 23a) (Type, Prin		2 .					
		1 '		Apor Va Desa 31 Date filed (Month, Day, Ye		00 Uppen 32. Registrar's Sign	Chesa	ocake i	Drive, E	sel Air	MD	21014	+	
		St Regist	ate trar	OCT 3	1 2005	Je. Syswar s sign	10 80							
	Dł	HMH 17 Rev 1/	4000		2000	Alice -	Se Special							
							ORIGINA	\L						

			1 - For State Registrar	State of Ma	aryland		artment of I rtificate of		Mental Hy	gienel ()	5	35087
			Decedent's Name (First, Middle, L.	ast)					2. Date of De	ath		3. Time of Death
	Physici /Medic		Charles Edward I	LIVINGSTON					Octobe		Year 0.5	1145 a. M
	Examir		4a. Facility Name (If not institution, gi	ve street and number)			4b. City, Town, o	or Location of Dea		4c. County of		
			45 South Colonia	al Drive			Hager				hing	ton
	Funeral		,	Sex 7. Ag 1 X M 2 ☐ F	e (In yrs. la		If Under 1 Year Months Days		n. (Month, Da	th y, Year)	9. Birthp	place (State or Foreign
	Director		198-18-6978	MW 201	80	Yrs.			Oct. 8	, 1925		msylvania
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation				1	Od. Inside City Limits
	Manyl f sho	ō	Maryland Washi	ington		Насе	rstown					1 ☐ Yes 2t No
	28a-	Je C	10e. Street and Number	LIIGCOII		nage	10f. Zip Code			10g. Citizen of W	hat Cour	ntry?
	72 hours after death with the Maryland naturel', or Items 23a or 28a-1 show iteal Examinat must be notified at	Funeral Director	45 South Coloni	al Drive			2174	40		USA		
	ms 2	era	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	13.	Was Decedent of I	Hispanic Origin?	(Specify Yes or No erto Rican, etc.)	- 14. Race		an Indian,
9	after or Ite		1 ☐ Never Married 2 X Married	1 Yes 2	No	i	ir res, speciny Cub 1 □ Yes 2 🛛 No		eno Hican, etc.)		, White,	etc.
5-0036	ours rel',	d by	3 Widowed 4 Divorced	Year or Dates:	WW I	I	10 103 200 110	Specily.		Specify:	W.	hite
5-0	72 h natu	Completed by	15. Decedent's 8 (Specify only highest g	Education rade completed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most of w	vorking	16b. Kind of Bus	iness/In	dustry
2	within ene. then *	m	Elementary/Secondary (0-12)	College (1-4or	5+)			od)		homo i	rama	deling
121	iled v Hygie Ither t	ပိ	8 17. Father's Name (First, Middle, Las	0		Carp	enter	18 Mother's N	ame (First, Middle,			uelliig
Maryland	ntal h	) Be	Earl Livingston						abelle Da		,	
2	hould Me mark mark matic	卢	19a. Informant's Name/Relationship			19b. Maili	ng Address (Street		Rural Route Numbe		State Zir.	(Code)
Z	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinst must be notified at ance.		Patricia Livings									land 21740
ē,	tem tem other		20a. Method of Disposition				sition (Name of matory or other pla		Date	20c. Location - (		
Baltimore,	Pages ent o nt: If i		1 ☐ Burial 2 X Cremation 3: 1 ☐ Donation 5 ☐ Other (Spec				vn Cremat		/17/05	Hagersto	17477	Maryland
äĦ	permit. Pa Departmen Importent: any injury once.		21. Signature of Europial Service Lice	ensee	* **-				INNICH FU			11017 2000
Ö	permi Departimpor any ir		Scott	MIIIL	me	1 /						land 21740
	28.0		23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that caused y one cause on each li	the death.	Do not en	er the mode of dy:	ng, such as cardi	iac or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		Lis.	~2	( O-	ser				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or s	a conseque	ence of):						
п	Examine		Sequentially list conditions,	b		0						
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence or):						
	xecut and II-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as	a conseque	ence of):						
60	icate be executed physician and s the burial-transit	aiE	(									
68760,		edicail		d								
Box	eath certil attending for use a	<u>N</u>	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			7F-4			23d. Date	of delive	ery
	death e atten ad for u	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant a			Ectopic pregnanc Other (specify) _	у		Mon	th	Day Year
P.0	w requires that the death cen been signed by the attendin should be detached for use	Completed by Physician/M	9 Unknown					-				
	res th ignec be de	by	Part II. Other significant conditions	contributing to death b	ut not resul	ting in the u	nderlying cause gr	ven in Part I.				ne cause of death?
ord	requii een s	ted							121	res 2□No 3	3 🗌 Prob	abły 4 🗌 Unknown
of Vital Records,	a taw has b e 2 st	npie							24a. Was autop	sy pr	ior to cor	psy findings available mpletion of cause of
E	: The law cate has I	Co									eath?	2 No
Vitt	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Ott	non	eath (Check only o			
of		To.	1 Yes 2 No	1 Inpatie	ent 2 E	R/Outpatier 28b. Time o	IL SEL DOA	4   Nursing	Home 5 Resid	dence 6 Other		y)
on	Attending Phyrr death. sctor: After thi	tion	1 Natural 5 Pending 2 Accident investigati	(Month, Da	y Year)	Injury	Wo	rk? ]Yes 2 □ No			_	
Division	Atten r dea sctor	ifica	3 Suicide 6 Could not	be 28e. Place of Inj	ury - At hon	ne, farm, st	eet, factory, office		28f. Location (5	Street and Number	r or Rura	l Route Number,
Ö	al or after	Certification:	4 Homicide	building, et	c. (Specify)				City or Tox	vn, State)		
	To the Hospitel or Attendir within 24 hours after death. To the Funerel Director: Al completely filled in by the fu	edical (	29a. Certifier 1 Certifying F (Check only one)	Physician: To the best aminer: On the basis of and manuer st	f examination	ledge, deat on and/or in	occurred at the ti	me, date and place opinion, death oc	ce, and due to the curred at the time,	cause(s) and man date and place, ar	ner as st nd due to	tated. the cause(s)
	Fo the	Me	29b. Signature and title of certifier				29c. Licens	se number		29d. Date signed	(Month,	Day, Year)
	C > F 0		the de me	II X	-	つかか	177	3622	t	White.	-17	2.411
			30 Name and address of person who	o completed cause of c	leath (Itemy	23а) (Туре,	Print)	, , ,	^			1003
51	441		fredere H	ASS 111	m	111	18 mec	leel	Canoul	Per 1-	100 B	ectourh
	Sta		31. Date filed (Month, Day, Year) OCT 18	107	ar's Signatu	ire	1				0	21747
	Regist		OCT 18	2005 Day	us 1	1. p	pere					-1112
171-	MH 17 Boy 1/2	P()()										

DHMH 17 Rev 1/2001

			For State Registrar	State of	Maryland /		artment rtificate			ınd Me		giene Reg. No.	005	35088
	Physici	an	1. Decedent's Name (First, Middle, L	ast)						1	Date of Dea	Day	Year	3. Time of Death
(1) (2) (3)	/Medic	100	MOCHING LAW  4a. Facility Name (If not institution, gi	ve street and numi	oer)		4b. City,	Town, or	Location o		OCTOBE	7	2005 County of Death	3:20 A <sup>M</sup>
	Examili	ei A	MONTGOMERY GENE				OI	LNEY				MOI	NTGOMER	Y
31.50 31.50	Funeral				. Age (In yrs. last		If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. 8 Min.	Date of Birt (Month, Day	h /, Year)	9. Birth Cou	place (State or Foreign intry)
b	Director		217-13-6020 Usual Residence of Decedent	1 2 2 1	84	Yrs.				M	AY 23,	192	1 CHI	NA
	/land		10a. State 10b. County		10c. City, To	own or Lo	cation							10d. Inside City Limits
	a-fsh	ctor	MARYLAND MONTO	OMERY	RO	OCKV:	ILLE							1 □ Yes 2 🛣No
	or 28	Directo	10e. Street and Number				10f. Zip	Code				10g. Citize	en of What Cou	intry?
	e 23a	erai	14500 MANOR PAR		ent Ever in U.S.	13	Was Dood	208.		nin? (Specif	fy Yes or No-	USA	4. Race - Amer	ican Indian
	fter de	Funeral	11. Marital Status  1 Never Married 2 Married	Armed Ford	:es? ! [ <b>T</b> YNo		It Yes, spec	ify Cubai	n, Mexican	, Puerto Ric	can, etc.)		Black, White	
9	ral', o	l by	3 ☐Widowed 4 ☐ Divorced	If Yes, Give Year or Dat			1□Yes 2	on <b>K</b> lz	Specify:			5	Spacify: ASI	AN
2-0	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Iteme 23a or 28a-f show ther than madical Examinar must be notified at	Completed	15. Decedent's (Specify only highest g		16	(Give	dent's Usua kind of wor DO NOT us	k done d	lurina most	t of working		16b. Kind	d of Business/li	ndustry
2	within ene. then	т	Elementary/Secondary (0-12)	College (1-	for 5+)		MEMAKI		,			O	WN HOME	
2	illed Hygi other	BeC	17. Father's Name (First, Middle, Las	st)		1101	ILITIMA		18. Mothe	r's Name (I	First, Middle,			
lar	uld be Menta irked itic ev	To B	UNOBTAINABLE						UN	OBTAI	NABLE			
lan	2 sho and l		19a. Informant's Name/Relationship	(Type, Print)	1	9b. Maifii	ng Address	(Street a	ind Numbe	or Rural F	Route Numbe	r, City or	Town, State, Zi	ip Code)
e,	1 and 1ealth sm 27 ther to		PING TONG HO/SC 20a. Method of Disposition	)N			MANO Sition (Nam		ARK D	R, RO			D 20853 ation - City or T	
nor	nt of the state of		1  ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		tate ceme	tery, crei	matory or or	ther place		Cm 1/	2005			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants: if item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at any injury or other traumatic event, the Madical Examiner must be notified at once.		21. Signature of Funeral Service Vice	100	GATE		HEAVEI 2. Name an				, 2005 S-RINA		LVER SP FUNERAL	RING, MD HOME
ä	Per		town !	dente	su-									G, MD 20904
8760,	Physician and // Medical Examiner  Characteristics of the principle of the	icai Examiner	234. Part1. Enthr the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	y one cause on ea  a Due to (o  b Due to (o	STROKE r as a consequence r as a consequence r as a consequence	ce of):	er me mou	o or dynig	y, suom as	Cardiac of 1	варнаюту аг	1631,		Approximate Interval Between Onset and Death
P.O. Box 68	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as it	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live bir	ome of pregnancy th 2  Fetal dea nt at time of death wn	ath 3[	□Ectopic pr □ Other (sp					23	3d. Date of deliv Month	very Day Year
S, D	ires that signed b d be deta	by Pl	Part II. Other significant conditions			g in the u	nderlying c	ause give	en in Part I.		+			the cause of death?
g	w require been sign	ted	HYPONATREMIA, I	ENCEPHALO	POTHY,				· · · · · · · · · · · · · · · · · · ·		101	res 2□	No 3□Pro	bably 4 XUnknown
ec	a law r has be e 2 sh	Completed	MALNUTRITION								24a. Was autop		24b. Were aut prior to co	opsy findings available ompletion of cause of
E E	r: The										1 Yes	2 <b>X</b> No	death? 1 ☐ Yes	2 No
Ĕ	siciar certif irecto	o Be	25. Was case referred to medical examiner?  1 \sum Yes 2 \sum Yes	Hospital: , X	patient 2 ER/	Outpation	nt 3 DC	Othe			Check only o		□Other (Spec	E.3
ō	Attending Physician: or death. sctor: After this certification of the funeral director, by the funeral director,	n: To	27. Manner of Death	28a. Date of		b. Time o		8c. Injury Work	4 🗀 170		d. Describe I			ny)
0	anding ath. or: Aft	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat	ion	, Day rear)	Injury	М		Yes 2 □	No				
Division of Vital Records,	tal or Atters as after de al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	286. Place	of Injury - At home g, etc. <i>(Specify)</i>	, farm, st	reet, factory	, office		28	f. Location (S City or Tox		Number or Rui	ral Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical		Physician: To the laminer: On the ba and mann	sis of examination						at the time,	date and p	place, and due	to the cause(s)
	To the vithin 2 To the complete	Σ	29b. Signature and title of certifier	1.0	On A.				number				signed (Month	
•	6		10/1		0 -0	in, M		D005	/630			Ucto	ber 12,	2005
			30. Name and address of person wh Anuradha Arun, I		01 Georg			#20	9 Sil	ver S	pring,	Mar	yland	20902
A Second	Sta Regist	ate rar	31. Date filed (Month, Day, Year) OCT 1 4 2		gistrar's Signature	Spe	de							

			1 - For State Registra MEND#20bp		of Marylai				lealth a Death	and Me		giene Reg. No	1000	35089
	Physici	an	1. Decedent's Name (First, Mid-								2. Date of Dea	Da	y Year	3. Time of Death
	/Medic	al		N M. LERNE			41.03	*		(5 )	SEP	28	2005	12:20
	Examin	er	4a. Facility Name (If not instituti NATIONAL NAV.	-		{	46. City		r Location o			40	. County of Dea MONTGO	
	Funeral		5. Social Security Number	6. Sex		. last birthday)	If Und	r 1 Year	If Under		8. Date of Birt (Month, Day	h Veer	9. Bir	thplace (State or Foreign
	Director		030-09-1825	1 <b>X</b> M 2□ F	86	Yrs.	IVIORITIS	Days	riouis		ug. 14	, 19	919 Otto	owa, Canada
	land ow		Usual Residence of Decedent  10a. State 10b. Coun	ty	10c. C	ity, Town or Lo	cation							10d. Inside City Limits
	Many a-1 sh	tor	MD Mont	gomery	Bet	thesda								1≹Yes 2□No
	hours after death with the Maryland turel', or Items 23a or 28a-1 show al Examiner must be notified at	Director	10e. Street and Number 5305 Strathmor	Λ				ip Code				10g. Ci	tizen of What Co	ountry?
	s 23a	rai				10 10		895				USA		
	iter de	Funerai	11. Marital Status  1 □ Never Married 2 □ Ma	Armed F	cedent Ever in U forces? 2 14 No		Was Dec If Yes, sp	edent of Hearty Cuba	ispanic Ori an, Mexican	gin? (Spec n, Puerto R	cify Yes or No- lican, etc.)		14. Race - Ame Black, Whit	
936	ral', o	by	3 ☐ Widowed 4 ♣ Divorce	If Vac G	ive		1 ☐ Yes	2 <del>∏</del> №	Specify:				Specify: Wh	nite
5-0	72 na	Completed		ent's Education lest grade completed	)	16a. Dece (Give	kind of w	ork done	durina mosi	t of workin	g	16b. K	(ind of Business	/Industry
121	within ene. than "	duic	Elementary/Secondary (0-12)	5+College	(1-4or 5+)		hysi	us <i>e retirec</i> cian	1)			Med	lical	
d 2	the the	യ	17. Father's Name (First, Middle	e, Last)					18. Mothe	r's Name	(First, Middle,	Maider	Sumame)	
ylar	ould be Mental Marked o	To B	Alexander Ler	ner					Jaı	net C	ohen			
Nar	12 sho		19a. Informant's Name/Relation		C. d a		-						or Town, State, 2	Zip Code)
e,	1 and Healt tem 2		August Zinsse 20a. Method of Disposition	r-Lawyer/	20b.	Place of Dispo	sition /Na	ame of	1	, Ken	sington	n , M	1D 2089 ocation - City or	
ПOП	ages ent of nt: If it		1 ☐ Burial 2 🔁 Cremation  4 ☐ Donation 5 ☐ Other		State	cemetery, cre Comfort	matory or	other plac		10-14			xandria,	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Ia marked any injury or other traumatic events.		21. Signature of Funeral Service		7	2:	2. Name a	nd Addre	ss of Facilit	Josep	ph Gawl	er'	s Sons	
<b>B</b>	8 9 E 8 8		July hond	reld sod	<u>u</u>	5	130 1	Visco	nsin	Ave.	N.W.,	WDC	20037	
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that st only one cause on	caused the dea each line.	ith. Do not en	ter the mo	de of dyin	g, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	SEPSI									
E	Examiner			Due to	o (or as a conse) MULTI	ORGAN	DYS	FUNCT	ION					
	₽ #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conse		20 200	. 01.01	2011					
	ecute and I-trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to	o (or as a conse	guanca of):								
8760,	cate be executed physician and the burial-transit			Due to	7 (01 as a conse	querice or).								
9	The law requires that the death certificate be executed te has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	ledicai		0.										
Вох	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant		utcome of pregr		Ectopic	oregnancy	,				23d. Date of de	
O.	at the dea by the at tached fo	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Preg 9□ Unk	nant at time of	death 5	Other (s	specify)					Month	Day Year
<u>α</u>	that the		Part II. Other significant condi	tions contributing to	death but not re	sulting in the u	nderlying	cause giv	en in Part J.		23e. Did to	bacco	use contribute to	the cause of death?
rds	quires an sign uld be	ed by									1 🗆 Y	es 2	<b>X</b> iNo 3□Pi	robably 4 Dunknown
ooe	law requir as been s 2 should	piet									24a. Was		24b. Were at	utopsy findings available completion of cause of
Vital Records,		Completed									perfor	rmed?	death?	2 □ No
Vita	Physician: The this certificate ral director, page	Be	25. Was case referred to medic examiner?	Usasitalı	5			OA Oth	05		(Check only o			
of		7: To	1 ☐ Yes 2 XNo  27. Manner of Death	1 12	Inpatient 2 of Injury nth, Day Year)	28b. Time o		28c. Injur	y at		e 5 Resid		6 ☐Other (Spe	cify)
ion	uttending death.	atio		stigation	ntn, Day Year)	Injury	М	Wor 1 □	k? Yes 2⊡!	No				
Division	or Attend after death Director: /	Certification:	3 ☐ Surcide 6 ☐ Coul 4 ☐ Homicide dete	minad   200. Flat	ce of Injury - At I ding, etc. (Spec	nome, farm, st	reet, facto	ry, office		28	8f. Location (S City or Tow	Street ai vn. State	nd Number or Ri e)	ural Route Number,
	spita ours ieral		29a. Certifier 1X Certify	ring Physician: To th	na hast of my lim	nowledge do-	h 000:	d at the t	no doto o-	dplace	nd due to the	20110-1-	) and manner	e etatod
	To the Hos within 24 ho To the Fun completely:	Medical	(Check only 2 Medic	al Examiner: On the	basis of examin nner stated.	ation and/or in	vestigatio	n, in my o	ne, date an pinion, dea	d place, ar th occurred	d at the time, o	date an	d place, and due	s stated. e to the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and title of certing	ier //			2	c. Licens	e number			29d. Da	ite signed (Mont	
)	12		In M	177	M.D.			A841	3 <b>6</b> (C	CA)		5	CP 29	7 2005
	1		30. Name and address of person			om 23a) (Type,	Print)				L MEDIC		CENTER	
	Sta	ite	SEAN A. MCKA 31. Date filed (Month, Day, Yes		Registrar's Sign	nature 🖋	. 10	BETH	IESDA	MD 20	0889-56	00		
	Registi		OCT 1	4 2005	aus 1	K A	artis)	65						

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Amend item#23a perME G848 10-28-05 TT
State of Maryland / Department of Health and Mental Hygiene O 5 1- State Registrar #23A, Line A, Per Physician, Certificate of Death 10/17/05. Amended Item Reg. NoWCHD Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Sharron Wilkins Lewis 10/14/2005 ar 9:50 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 12512 Fleetway Drive Worcester Ocean City 5. Social Security Number 8. Date of Birth (Month, Day, Year) 06/10/1942 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 XF 63 Yrs. 213-44-0977 Director MD Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ir than "natural", or Itams 23e or 28e-f show the Medical Examiner must be notified at MD Worcester Ocean City 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? W. 12512 Fleetway Drive 21842 USA death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 2 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7: th and Mental Hygiene. 7 Is marked other than "n. College (1-4or 5+) Elementary/Secondary (0-12) Teller Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Maurice Wilkins Betty Gordon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) iges 1 and 2 s nt of Health an 12512 Fleetway Dr. Ocean City, MD 21842 Benjamin Lewis (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 Surial 2 Cremation 3 Removal from State ö permit. Page Department of Important: If any injury or Evergreen Cemetery 10/17/2005 Berlin, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

108 William Street Berlin, MD 21811 20a. Part1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List entry one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Hypertensive cardio-respiratory disease disease or condition resulting in death) few\_years /Medical Due to (or as a consequence of): Examiner PERILIV Sequentially list conditions, Examiner d any leading to immedicause. Enter Underlying Cause (Disease or injury as the burial-transit certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. | the 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? NOW 23 A Division of Vital Records. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ∰Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗆 No 2 No 1 ☐ Yes 1 Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification 28d. Describe how injury occurred After or Attanding Injury 1 Natural 5 Pending after death. Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0. 106241 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) gistrar's Signature State Registrar

Physician   JAMES   MCCRAY   Month   Cay   Year   23.23 A	4		1 )	e bisi-	•		- 133	SE	PTEMBER 28	, 2005
Physician   Middle   Comment   Ferrity Name   (Ferrity Name   Ferrity Name   (Ferrity Name   Ferrity Name   F	5 5 5 S	_	255. Signature and fille of certifier						-	///
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Privacian   Medical Examiner	ing Phys fiter this uneral di	To B	examiner? 1 XYes 2 No  27. Manner of Death 1 XNatural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time	of 28c. Inju	her: 4 Nursing iny at irk?	Home 5 Resid	ence 6 10ther (Spe	
A Facility Name of front institution, plus street and number   Sect Pleasant Maryland   Prince George   Section	an: The law re tificate has bei tor, page 2 sho	a					26. Place of D	autop: perfor 1 Yes	sy prior to death? 2 No 1 Yes	completion of cause of
Physician   Medical Examiner	quires that en signed t	by	Part II. Dther significant conditions of	contributing to death but not r	esulting in the	underlying cause gi	ven in Part I.			
Physician   Medical   Asaminer	the death certifica by the attending phached for use as the	hysician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time o	etal death 3		cy .			•
Physician   Ale Cally Name (if not institution, give street and number)   See The Pleasant Maryland   Ac. County of Death   Prince George   Specify   See The Pleasant Maryland   Prince George   See The Pleasant Maryland   Prince George   See The Pleasant Maryland   Prince George   Prince	ate be executed sysician and he burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a cons						
Physician / Medical Examiner   As Facility Name (if not institution, give street and number)   Seat Pleasant Maryland   As County of Death   Seat Pleasant Maryland   Prince George   Top-16-3140   Top	/Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.  END STAGE	DEMENT		119, 00011 40 0413	20 or 100pmatory an		Interval Between Onset and Death
Physician //Medical Examiner  4a. Facility Name (If not institution, give street and number)  520 69th Place  5. Social Security Number 719-16-3140  1 X M 2 F 90 Yrs.  4b. City, Town, or Location of Death Seat Pleasant Maryland Prince George  Seat Pleasant Maryland Prince George  5. Social Security Number 719-16-3140  1 X M 2 F 90 Yrs.  4b. City, Town, or Location of Death Seat Pleasant Maryland Prince George  1 Year 28, 2005  4c. Country of Death Prince George  1 Year 1 Year If Under 24 Hrs. Months Days Hours Min. Month, Day, Year)  1 Year 2005  1 Year 28, 2005  4c. Country of Death Prince George  2 Seat Pleasant Maryland Prince George  3 Seat Pleasant Maryland Prince George  5 Social Security Number 719-16-3140  1 Year 1 Year If Under 24 Hrs. Months Days Hours Min. Days Hours Min. July 28, 1915 Americus GA	permit. Depart Import any in.		I Dende da	yl-	1	661 Good	Hope Rd	SE, WashD	C 20020	
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Physician /Medical Examiner    Month   Day   Year   28, 2005   3:23 A	uld be file Aental Hyy rkad othe tic evant,	Be							Maiden Surname)	
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Physician /Medical Examiner  JAMES MCCRAY  SEPTEMBER 28, 2005  4a. Facility Name (If not institution, give street and number)  520 69th Place  Seat Pleasant Maryland  Prince George	Director	ļ	719-16-3140 1	90			Hours Mi	July 28	8,1915 Ame	ricus GA
Physician /Medical JAMES MCCRAY SEPTEMBER 28, 2005 3:23 A		G!		ex 7. Age (In yn	s. last birthday	If Under 1 Year	If Under 24 Hi			
	/Medic	al .			Υ	4b. City, Town, o	or Location of Dea	SEPTEMBE	ER 28, 2005	
Hegistrar Continuate of Document Hegistrar			The Registrar  1. Decedent's Name (First, Middle, Last	st)	Ce	rtificate of	Death	2. Date of Dea	ith	35091 3. Time of Death

AEM # 05-07148

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/Medi	ian	ahon  1 - State Unpend Item  1. Decedent's Name (First, Middle, Lasi	)			2. Date of De Month	Day	Year	3. Time of Death
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Funeral		Social Security Number     6. Se		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	th	9. Birth	place (State or Fore
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or 28	- ie	10e, Street and Number		10f. Zip Code			10g. Citizen of	What Cour	ntry?
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Pari, or	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🖾 No	Specify:		Spec	ity: WH]	ITE
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ked o	To Be	MARK MULLIGAN	, SR.		MARIANN		ILDERS	1110)	
h and Men 7 ie marke traumatic	۲	19a. Informant's Name/Relationship (T)	ype, Print) 19b. Maili	ng Address (Street	and Number or Ru	al Route Numbe	er, City or Town	n, State, Zip	Code)
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t of Heelt if item 2 or other		20a. Method of Disposition t □ Burial 2 □ Cremation 3 □ F	20b. Place of Disposementary, cre	osition (Name of matory or other place	Θ)	Date	20c. Location	- City or To	own, State
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Department important: eny injury conce.		21. Signature of Euneral Service Licens	/ / /	2. Name and Addres		SERVI	CE. D	7.	
. U . E • Q		220 Part 1 Enter the disease or comp							
		shock, or heart failure. List only o	licitions that ceused the death. It mot en	er the mode of synn	g, such as carpiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
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as been signed by the attending ph 2 should be detached for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy				23d. Da	ate of delive	erv
e atte	Physiclan/M	in the past 12 months? 1 ⊋Yes 2 □ No	4 Pregnant at time of death 5	□Ectopic pregnancy □ Other <i>(specify)</i>				onth	Day Year
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should t	ted	Obesity				1 🗆 Y	es 2□No	3 🗌 Prob	ably 4.20Unkno
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ate h page	Be	25. Was case referred to medical examiner?	fospital:	othe Othe	26. Place of Deat			-	
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ate has page 2	To It		(Month, Day Year) Injury		? /es 2 ☐ No		,-,,		
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leath. <b>tor: A</b> fter this certificate has the funeral director, page 2		t Autural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, sti	reet, factory, office			II, State/		
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24 hours after death. Funeral Director: After this certificate hitely filled in by the funeral director, page	Certification;	t Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exami	building, etc. (Specify)	h occurred at the tim vestigation, in my op	pinion, death occur	and due to the cred at the time, c	cause(s) and m date and place,	and due to	the cause(s)
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24 hours after death. Funeral Director: After this certificate hitely filled in by the funeral director, page	Certification;	t Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (check only one)  29b. Signature and title of certifier	building, etc. (Specify)  sician: To the best of my knowledge, deat ner: On the basis of examination and/or in	h occurred at the tim vestigation, in my op 29c. License OCM	pinion, death occur	and due to the cred at the time, c	cause(s) and m date and place, 29d. Date signs	and due to	the cause(s)

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** october 25 WILLIAM 2005 ARTHUR MENCH 1:10a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Chester River Hospital Center Chestertown Kent If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye June 11 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Year) Hours Min 11XIM 2□ F 1929 76 Maryland Director 218-26-0991 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner mast be notified at Chestertown MD Kent 1 TarYes 2 □ No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 818 High St. 21620 U.S.A. death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No 1951 If Yes, Give Year or Dates: -1953 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 White 1 ☐ Yes 2 € No Specify: δ Specify 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Service & Delivery Man Retail Gas Company 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Mench Hallie Joiner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s' of Health ar f Item 27 ir or other trr David A. Mench (son) 1601 McGinnis Rd. Chestertown, MD. 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 nent of H ant: If Ite ury or otl 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Chester Cemetery 10/28/05 Chestertown, MD. 4 ☐ Donation 5 ☐ Other (Specify) Galena Funeral Home of Stephen Schaech M00510 118 West Cross St. Galena, MD. 21635 Approximate Interval Between Onset and Death 23a. Pant1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Immediate Cause (Final Physician <Smin Hemopty513 disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Poorly Differentiated pon Small Coll Ling Country Mouths Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner with mots. attending physician and I for use as the burial-transit that initiated events certificate be exec resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant The law requires that the death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a ☐Yes 2☐No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown pinous Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2.0 No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred of or Attanding F safter death. I Diractor: After After Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0050996 05 4+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neil Stoddard M.D. 100 Brown St. Chestertown, MD. 21620 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 2005

		-	For State Registrar	State of	Marylan		artment o			ınd Mer	ntal Hy	giene Reg. 2.0	105	350	94
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<u>\</u>	d Men narke	P	Matthew McGuire  19a. Informant's Name/Relationship	(Type Brint)		10b Mailie	ng Address (S			erine			oum State 7	in Cada)	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "naturel", or Items 23e or 28a-f ehow amportent: If item 27 is marked other than "naturel", or Items 23e or 28a-f ehow amportent: If item 27 is marked other the Maryland or other treumatic event, it is Mariesi Exercities must be inclined at once.		Phyllis L. McGui		se		Sunny E					012 G	aither		77
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Baltimore,	epartr poort ny inj		21. Signature of Funeral Service Lic	eesne			. Name and A								
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			30. Name and address of person what Kirti Vohre, M.I					esda	ı, Ma:	ryland	2081	7			
	Sta	ate	31. Date filed (Month, Day, Year)	32 Re	egistrar's Signa	ature -	201								
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			For State Registrar		State of	of Mary	land				ealth a		ental Hy	giene	005	35095
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	/Medic Examin		4a. Facility Name (If not institu			ımber)			4b. City,		Location o	of Death			County of Dea	th
			16051 Anima I	rive 6. Se		7 Age (Ir	vre la	st birthday)	Bt If Under		nsvil		9 Date of Birth	h	Montgo	
	Funeral Director		069-32-7629 Usual Residence of Decedent	10	_ M 2☐¥F	7. Age (iii	66	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da March I	5 , Year)	939 N	thplace (State or Foreign ountry) ew York
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	Physician /Medical		23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	, or comp List only o	a. Bla	each line.	Can	Do not ent								Approximate Interval Between Onset and Death 2 Years
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Division	of or Atter after dea Director d in by the	Certification:	3 ☐ Suicide 6 ☐ Co	uld not be ermined	28e. Place build	e of Injury - ling, etc. (S	At hom Specify)	ne, farm, str	eet, factory	r, office		2	8f. Location (S City or Tow		l Number or Ru	ural Route Number,
	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer.	edical C	29a. Certifier 1 Certifier (Check only one)	fying Phy cal Exem	iner: On the t	e best of m pasis of exa	aminatio	ledge, death on and/or in	occurred estigation,	at the tim	e, date an	d place, a th occurre	nd due to the ded at the time, d	ause(s) late and	and manner as place, and due	s stated. B to the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Reg. No. UU Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 1900 10 13 2005 /Medical 4b. City. Town, or Location of Death 4c. County of Death **Examiner** *111564*5 Moonico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Funeral Birthplace (State or Foreign Country) Months Days Hours Min. 16-54-Director 6 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits MD 1 Yes 2 □ No Completed by Funeral Director Wicdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1□Yes 2 No Specify: Specify: BIACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Line Worker 12th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2011 Sert Thomas Martin 1001919 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place)

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20c. Location - City or T Dulis Martin Sister 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** INTRAVENTRICULAR HEMORRHAGE /Medical **Examiner** HYPGRIGUSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner physician and s the burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 → Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

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DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of	Marylar		artment rtificate				ental Hy	-	2005	35097	,
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Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygierie is marked other than 'natural', or itema 23a or 28a-f show aumatic event, it a Medical Exarchiat missible but aumatic event, it a Medical Exarchiat missible but an experience of the modified at	To	Guy Wingerd St	amy					A.	nna N	Mary Ha	artma	an		
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esî Osî	l and 2 lealth a	1	Dennis J. Miller	(Son)	20h	250 Z		THE RESIDENCE	oad C.				A 17201		
Baltimore,	Pages nent of H int: If ite		20a. Method of Disposition  1-∑ Burial 2 ☐ Cremation 3 ☐		ate	cemetery, crei	natory or oth	her place			ate 2005		ocation - City or To		
Ξ	permit. Pag Department Important: any injury c	1	4 □Donation 5 □ Other (Specify, 21. Signature of Funeral Service License		L1	ncoln (	Cemete  Name and				er 19,		nambersbu		_
Ba	permit. Pag Department Important: I any injury o		21. Signature of Pulleral Service Licens		. 44	1							Funeral	Home and 21783	
*	- 35		23a: Part1. Enter the disease, or comp	lications that cau	sed the dea								, margra	Approximate	-
74	Physician		shock, or heart failure. List only of Immediate Cause (Final			-0010	070	0	,	10		25		Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	a Due to (or	as a consec	SPIR quence of):	10	1- 7		1-1-)	1201		14	HOURS	
	Examiner		Harman Carlotte Company			TERM								20275	
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consec	quence of):									_
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c											
8760,	cate be executed physician and the burial-transit	al E		Due to (or	as a consec	quence or):									
687	phys phys s the	dlcal		d											
	death certific e attending p d for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. if yes, outco									23d. Date of delive	NOV.	
ğ	death a atter	Iclar	in the past 12 months?	4 Pregnar	h 2∏Feta ntattime of o		]Ectopic pre ] Other (spe						Month	Day Year	
P.O. Box		hys	9 Unknown	9 Unknow	n 										_
	The law requires that the ite has been signed by th page 2 should be detache	by P	Part II. Other significant conditions co			_		-			23e. Did 1	obacco i	use contribute to th	e cause of death?	
ord	equir en si ould	ted	CONGESTIV	E 17	EAR	7	FAI	1010	2E		1 🗆	Yes 2	□ No 3 □ Prob	ably 4 🖾 Únknown	
ပ္ပ	law ras be	Completed									24a. Was	an DSV	24b. Were autoprior to con	psy findings available inpletion of cause of	
Vital Records,		Con									perfo	ormed? 2 ☑ No	death?	2 No	
<u> </u>	ysician: Th	Be	25. Was case referred to medical examiner?	Hospital:				(			Check only				_
0	Phys this ral dir	. To	1 ☐ Yes 2 ☑ Ño  27. Manner of Death	1 🖭 lnp		28b. Time of			4 🛄 1401		e 5 Resi		6 Other (Specify	)	_
5	ding I h. After funer	ton	1 ☑Natural 5 ☐ Pending	28a. Date of (Month,	Day Year)	Injury	M Zo	C. Injury Work:	es 2∐1		ou. Describe	now injur	y occurred		
Division of	Atten deat ctor: y the	Certification:	3 Suicide 6 Could not be	28e. Place of	Injury - At h	ome, farm, str					8f. Location (	Street an	d Number or Rura	I Route Number,	_
á	al or A s after i Direction by	ert	4  Homicide Getermined	building	, etc. <i>(Speci</i>	(y)					City or To	wn, State	)		
	Hospital or Attending Physician: 44 hours alter death. Funeral Director: After this certificitiety filled in by the funeral director.	edical (	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	sician: To the be	est of my kno	owledge, death	n occurred a	it the time	e, date and	d place, ar	nd due to the	cause(s)	and manner as st	ated.	_
	To the I within 2 To the I complet	Med	oney	and manne	r stated.			License							_
	N N N		29b. Signature and title of certifier	1	n	/)			0 6 / 4	- 10			te signed (Month, I		_
		,	20 Name and addition of the same	omploted sausa				200	6/9	-10			061,16	6, 2005	_
H.	4		30. Name and address of person who c					E.	Anti	etam	St. Ha	gers	stown,Md.	21740	
	Sta	te	31. Date filed (Mon OPT Year) 20	32. Reg	istrar's Sign	ature									_
	Registr		001 13 2	COL	lua	1. A.	1.20								

State of Maryland / Department of Health and Mental Hygien 2005

35098 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year **Physician** DAVID 10 MINARD 09 2005 /Medical 4a Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner CAMBRIDGE, MD DORCHESTER CHESAPEAKE W0005 CENTER | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | MAY 23, 19 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** 212-38-6677 Yrs Director 92 1913 N. DÁKOTA Usuat Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mental Hygiene. important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinat must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No MD DORCHESTER Director CAMBRIDGE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21613 Funerai 525 GLEN BURN AVE. USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: <u>م</u> Specify: WHITE 3 Widowed 4 Divorced Year or Dates: Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MEDICAL DOCTOR 12 HEALTH CARE 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Be ACHIBALD MINARD GLADYS PEASE 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 5547 BONNIE BROOK, CAMBRIDGE, MD 21613 DOROTHA J. MINARD/WIFE 20a. Method of Disposition
1 □ Burial 2 ➡ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State CHESAPEAKE CREMATION CTR. 10/10/2005 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA Ostronely C. F.S.C. 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Intervat Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical End Stage Dementic Examiner Physician/Medical Examiner attanding physician and for use as the burial-transit The law requiras that the death certificate ba axecuted Sequentielly list conditions, if any, teeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760. Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown been signed by should be deta à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? certificata has t director, paga 2 s àZÎ No 1 TYes 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၀ 1□ Yes 2□ No this 28a. Date of Injury (Month, Dey Year) Certification: 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 TYes 2 □ No death. i Director: A 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. edicai 29a. Certifier (Check only 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D 47924 10-10-05 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) CAMBRIDGE MD 216/3 THANW 300 AURORA VOMAN 32. Registrar's Signature State Registrar

**DHMH 16 Rev 6/95** 

Cardell Montague 05-07099

d1			= State Unpend Item	State of M	laryland / D	epartmen	t of He	ealth a	nd Mer	ntal Hyg	iene	E 0	0000
	10000				.,27 per u	Certificati	e of E	reath					5099
п	Physici	an	1. Decedent's Name (First, Middle, L	•						Date of Deat Month	Day	Year	3. Time of Death
le le	/Medic Examin		Cardell Hilton  4a. Facility Name (If not institution, g			4b. City,	Town, or	Location of		)ctobe1	19, 20		6:30P <sup>™</sup>
	Examin	C1	4112 Weatherburn		•	Wald	orf				Charle	) S	
9	Funeral		Social Security Number 6.		ige (In yrs. last birth	(day) If Under		If Under 2	4 Hrs. 8. Min.	Date of Birth (Month, Day,		O. Diskerie	e (State or Foreign
J	Director		577-68-2418	HEM ZOF	54 Y	rs.			M	arch 7	, 1951	Washir	ngton, D.C
	aryland •how		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location						10d.	. Inside City Limits
	r 28a-f ehow	to	Maryland Charles		Waldorf								M Yes 2 □ No
	or 28s	Director	10e. Street and Number			10f. Zip					0g. Citizen of W	· ·	
	ath wi	ra	4112 Wetherburn				601				United :		
Baltimore, Maryland 21215-0036	within 72 hours after deeth with the Maryland ane. than "natural", or Items 23a or 28a-f ehow he Madical Exhmitier naut De notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Deceder Armed Forces 12 Yes 2 [ If Yes, Give Year or Dates	<sup>]</sup> №1975	13. Was Deced If Yes, spec		spanic Origi n, Mexican, Specify:	in? (Specify Puerto Rica	Yes or No- an, etc.)		- American K, White, etc Blac	2.
5-0	72 ho	eted	15. Decedent's (Specify only highest of			Decedent's Usua Give kind of wo	rk done di	uring most	of working		16b. Kind of Bus	siness/Indus	stry
121	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life. DO NOT u: erating					Smiths	onion	
d 2	Hygin Ther nt, I	ပိ	17. Father's Name (First, Middle, La.	st)		CIACINE			's Name (F	irst, Middle, N	Maiden Sumame		
an	should be filed and Mental Hygi s marked other umatic event, I	To Be	Morris H. Montag	gue				Juan	ita B	rown M	ontague		
ary	shou and M s mar		19a. Informant's Name/Relationship	(Type, Print)		-					City or Town, S	State, Zip Co	ode)
Σ,	and 2 ealth m 27 i		Betty Montague	(spouse)		2 Wethe		n Pla			•	0601	
ore	T S S S S S S S S S S S S S S S S S S S		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3	☐Removal from Stat	e cemetery	Disposition (Nar r, crematory or o	ther place		Date		20c. Location - (		
ţ	t. Partmen		4 Donation 5 Other (Spec		Ft. Li	ncoln C		- 1			Brentwoo	-	
Bai	permit. Pages 1 and 2 should b Department of Health and Menta Important: if Item 27 is marked any inlury or other traumatic e once.		21. Signature of Funeral Service Lic	B. Clyl	un	7400 G	eorg	ia Av	e. N.	W., Wa	neral Se shington	n, D.C	
8760,	Physician Medical Examiner and physicien and physicien and physicien and street the physician	dicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	s a consequence of as a consequence of a consequ	f): ().	comp1	icating	g liver	cirrhos	sis		nset and Death
.O. Box 6	Attending Physician: The law requires that the death certific rideath.  sector: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No		2 Fetal death at time of death	3 □Ectopic pi 5 □ Other (sp					23d. Date Mon	of delivery th Da	ay Year
rds, P	quires that en signed b uid be deta	ed by PI	Part II. Other significant conditions History of Hepat		but not resulting in	the underlying o	ause give	n in Part I.			oacco use contri es 2 □ No	bute to the o	- 4
Il Reco	The law requirate has been page 2 should	Completed by								24a. Was a autops perform	ned? de	eath?	y findings available letion of cause of No
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe			heck only on			
Division of Vital Records, P.O.	uttending Physical death. ctor: After this y the funeral did y	ation: To	Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident Investigat	28a. Date of Ir (Month, I			28c. Injury Work		28d		ence 6 Othe		scene
Divis	tal or Attenders safter death	Certification:	3 Suicide 6 Could not determine	28e. Place of building,	Injury - At home, far etc. (Specify)	m, street, factor	y, office		28f.	Location (St. City or Town	reet and Numbe n, State)	r or Rural R	loute Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical (	29a. Certifier 1 Certifying (Check only one)	Physician: To the be aminer: On the basis and manner	of examination and	death occurred for investigation	at the tim , in my op	e, date and inion, death	place, and h occurred a	due to the ca at the time, da	ause(s) and mar ate and place, a	nner as state nd due to th	ed. e cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	1.		290	. License	number E		2	9d. Date signed	(Month, Da	y, Year)
	10		Thereby	M. K.	& rus						ctober 2		
			30. Name and address of person wh	o completed cause o	death (Item 23a) (	Type, Print) 1	11 Pe	enn St	treet	Balti	imore, M	laryla	nd 21201
C	Kould		31. Date filed (Month, Day, Year)	Kang 30 Bari	strar's Signature								
	Sta Regist		OCT 2 5	2005	w B.	Sperle							

			For	State of Ma	aryland	i / Depa	rtment o	f Health a	and Me	ntal Hyg	iene	3.2	
			State Registrar			Cer	tificate c	of Death		R	eg. Nq	005	35/00
	Physicia	an	Decedent's Name (First, Middle,	•						Date of Deat Month	Day	Year	3. Time of Death
	/Medic	al		EAL			4h Cib. Tour			Octobe:		, 2005	11:35 A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, FREDERICK MEM	•				n, or Location o DERICK	of Death			ounty of Death	
	Funeral	***		6. Sex 7. Aq	e (In yrs. la	ist birthday)	If Under 1 Ye	ar If Under		Date of Birth			place (State or Foreign intry)
	Director		435-42-8416	1 <b>∑</b> M 2□F	80	Yrs.	Months Da	ys Hours	Min.	(Month, Day,			intry) Lucky
	pug »		Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Lo	cation						10d. Inside City Limits
	Maryli f sho	ō	Maryland Carr	o11									1 ☐ Yes 2 X No
	r 28a	Director	10e. Street and Number	711		<u> </u>	10f. Zip Cod	le		1	0g. Citize	on of What Cou	intry?
	death with the Maryland rme 23a or 28a-f show rmust be notified at		3515 Runnymede	Rd., Glenbuı	rn Fai	cm	217	87			U	nited S	States
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	)	S. 13. V	Vas Decedent Yes, specify C	of Hispanic Ori Cuban, Mexican	igin? (Specif	y Yes or No- can, etc.)	14	Race - Amer Black, White	
30	hours after turef', or ite	by Fi	1 Never Married 2 Marrie 3 Widowed 4 Divorced	ed 1X Yes 2 1 If Yes, Give Year or Dates:	No		Yes 2X	No Specify:			S	Specify: Wh:	ite
215-0036	within 72 hours after death with the Maylan jiene. Then "naturel", or liente 23a or 28a-f show the Madical Examinar must be notified at		15. Decedent'	's Education			lent's Usual Oc				16b. Kind	d of Business/h	ndustry
לו נו	e. en "n Med	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. L	kind of work do DO NOT use re	ne auring mos tired)	st of working				
2	filed within 7 Hygiene. other than "r ent, Ing Mad	Con		5+		Prof	essor					ucation	1
and	9 2 3	Be	17. Father's Name (First, Middle, L Chester Neal	.ast)						First, Middle, I	Maiden S	umame)	
Maryland	should Ind Men	٢	19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailin	g Address (Str		pie No er or Rural F		City or	Town, State, Z	p Code)
	and 2 sealth ar n 27 is		Elizabeth B. Ne			201	Runny		m			ryland	
altimore,	of H		20a. Method of Disposition	2 Demoual from State	20b. Pla	ace of Dispo metery, cren	sition (Name of natory or other	place)	Date	100	-	ation - City or T	
Ĕ	Pages ment of I ant: If Its ury or o		1 ☐ Burial 2 ② Cremation 4 ☐ Donation 5 ☐ Other (Sp		Fred	derick	Cremat	ory					Maryland
Ball	permit. Page Department of Important: If any injury or pace.		21. Signature of Funeral Servica L	icensee	11.		. Name and Ad					eral Ho	
	40260		23a Part 1 Foter the disease dr	complications that cause	the death		1621 Op					ICK, MI	Approximate
2	Thursdallon		23a Part1. Enter the disease, or heart failure. Eist of Immediate Cause (Final	only one cause on each li	ne.	10 da . +	- =	lun	1 0/10	י משער			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	aDue to (or as	a consequ	ence of):	weeth	1	/ 274		-		
	Examiner		Sequentially list conditions	b. ————									
- 24	sit ad	Iner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a cunsaqu	erice of).							
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequ	ence of):	_		-				
/60	ate be executed hysician and the burial-transit	calE		d									
9	The law requires that the death certificate tie has been signed by the attending phys age 2 should be detached for use as the I		15 555										
Box	eath certific attending p I for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth			]Ectopic pregna	ancy			23	d. Date of deli-	very Day Year
o H	at the dea by the at tached fo	sici	1 Yes 2 No	4□Pregnant at 9□ Unknown	t time of de	ath 5□	Other (specify	")				MOHUI	Day 1 bat
<u>.</u>	thet the		Part II. Other significant condition	ns contributing to death b	out not resu	Iting in the ur	nderlying cause	given in Part I.		23e. Did tot	pacco use	e contribute to	the cause of death?
Records,	w requires thet been signed b should be deta	d by	Typeetive	c with on	rena	cillin	resest	ant		1 🗆 Ye	s 2 🗆	No 3 Pro	bably 4 DUnknown
O O	aw rec s bee	Completed	Stap	havecal	au	reces				24a. Was a	n	24b. Were aut	opsy findings available ompletion of cause of
۳. س	The lav	mox								autops perform	ned?	death?	252 No
Ita	icient: 1 certificel rector, p	Bec	25. Was case referred to medical examiner?							Check only on	e)		
5	Physic this co	၉	1 ☐ Yes 2 ☑ No	Hospital:			t 3 DOA	Other: 4 Nu					r(y)
UQ O	ding f h. After luner	tlon	27. Manper of Death  1 Natural 5 Pending 2 Accident investig		iy Year)	28b. Time of Injury		njury at Work? 1 □ Yes 2 □		d. Describe ho	w injury	occurred	
Division of Vital	Atten r deat ector: by the	ifica	3 ☐ Suicide 6 ☐ Could n	not be 28e. Place of Inj	jury - At hor	me, farm, str						Number or Rui	al Route Number,
á	s after all Dire	Certification:	4 Homicide	building, et	tc. (Specify)	)				City or Towr	, State)		
	To the Hospital or Attending Physicient: within 24 hours after death. To the Funeral Director: After this certification in the funeral director, and the funeral director.		(Check only 2 Medical E	g Physician: To the best Examiner: On the basis o	of examinati	vledge, death	occurred at the	e time, date an ny opinion, dea	nd place, and ath occurred	d due to the ca at the time, da	ause(s) a ate and o	nd manner as lace, and due	stated. to the cause(s)
	thin 2, the I	Medical	one) 29b. Signature and title of certifier	and manner sta	ated.			ense number				signed (Month	
			fay	u mn	,				c				
	AVIX		30. Name and address of person v			23a) (Type,		DD54636	0		10/	15/2005	
11	λ,		Sved Hague, I	MD 700 Monto	laire	e Ave.	. Frede	rick, N	MD 217	01			
8	Sta		31. Date filed (Month, Day, Year)	2005 Registr	rar's Signat	ure /	alls!						
	Registi	ar	001 10	TOOL TOO		1							

DHMH 17 Rev 1/2001

State Registrar

Mohit

31. Date filed (Month, Day, Year)

9901

D0063088

Medical Center Pr.

October

Rock ville,

RASTOGI, PHYSIAN

Registrar's Signature---

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

16 astoqui

7 2005

M.D

	1		For Amend Item 26 State of Maryland / De	partment of Health and N			35102
·		_1	Registrar WCIID/ SII 11/10/05 PEL DL.	ertificate of Death	2. Date of Death	g. No.	3. Time of Death
	Physicia		1. Decedent's Name (First, Middle, Last)		October	Day Year	r
	/Medic	ai	Veronica Dorothy Nairn	4b. City, Town, or Location of Death	OC COLC.	4c. County of De	
	Examin	er 4	4a. Facility Name (If not institution, give street and number)	Hagerstown			ton County
			1088 Bramly Drive  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. B	irthplace (State or Foreign
	Funeral Director		215–20–6692 1□ M 2⊠ F 80 Yrs.	Months Days Hours Min.	Aug. 26,	1925 M	aryland
		Ī	Usual Residence of Decedent				10d. Inside City Limits
	yland		10a. State 10b. County 10c. City, Town or				1 StYes 2 □ No
	a-fs	cto	Maryland Washington Co. Hagerst			g. Citizen of What (	
	ith the	Directo	10e. Street and Number	10f. Zip Code	10	U.S.A.	Southly:
	ath w	ra	1124 Fairview Road	21742	pacify Yas or No-		merican Indian,
8	n 72 hours after death with the Maryland "naturel", or items 23a or 28a-f show edical Exercites from the rediffical at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Amed Forces?  1 Yes 2 M2No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Sin Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 ☒ No Specify:  1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)	Specify: Wh	hite, etc.
215-0036	hours		15 Decedent's Education 16a, De	cedent's Usual Occupation		6b. Kind of Busines	
င်	"na	Completed	(Specify only highest grade completed) (G	ve kind of work done during most of wor . DO NOT use retired)	king		
212	s withir jiene. r than	mo m	Elementary/Secondary (0-12) College (1-4or 5+) Sec	retary		Tire Com	pany
	filed within Hygiene. other than	a	17. Father's Name (First, Middle, Last)		ne (First, Middle, M	faiden Surname)	
land	o d a b	To B	Lloyd L. Welsh, Sr.		. Carey		
Mary	should and Men le marke eumatic		Total Milanda Maria	ailing Address (Street and Number or Ru			
	rt 2 mg		OOL Plans of Di	4 Fairview Road Ha	gerstown,	Marylan  Oc. Location - City	d 21742 or Town, State
altimore,	Pages 1 aunent of Hearning or other		cemetery,	ven Cemetery Oct. 1			
Ē	ment tant:		4 Elbertation & Electrical (explanation)				
Ball	permit. Pages Department of Important: If I any injury or once.		21. Signature of Financial Service Licenses Pauley JR	22. Name and Address of Facility Do 1331 Eastern Blvd.	N. Hager	stown, M	aryland 21/42
Ι,	64		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
100	Physician	9	Immediate Cause (Final disease or condition	ua.	,		Lyn
	/Medical Examiner		resulting in death)  Due to (or as a consequence of)	ule: Lon			Months
	Examine	L	Sequentially list conditions, deep leading to immediate  b. Due to (or as a consequence of)	garaic			
	ed sit	lhe	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	treun e	J.		month
	ate be executed by sician and the burial-transit	Examlner	that initiated events c. Due to lor/as a consequence of)	1	1		
8760	sician buria	Ical E	ty Hupe	rleusten			Jeans
687	ficate p physics the						
Box	death certifica te attending ph ed for use as ti	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 ✓ Fet i death	3 □Ectopic pregnancy		23d. Date of Month	delivery Day Year
	death e atte	lcia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	5 Other (specify)		IVIOITET	bay , ou.
P.0	y the	hys	9 Unknown	to the second in Rest	23a Did to	pacco use contribut	e to the cause of death?
	es tha igned be de	by F	Part II. Other significant conditions contributing to death but not resulting in the	To underlying cause giver in Part I.	1 🗆 Ye		Probably 4 □Unknown
ord	w require been si should I		011001000	· His	<del></del>		
Records,	2 50	ompleted	1 Jumobil	icy	24a. Was a autops perforr	n 246. Were prior death	a autopsy findings available to completion of cause of h?
=		Con	V		1 ☐ Yes	2 1 1	Yes 2□ No
Vital	icien: T certifical rector, p	Be	25. Was case referred to medical examiner?  Hospital:	Other	ath (Check only on		Specify) Daughters
of	phye this al dii	<u>2</u>	27 Manner Death 28a, Date of Injury 28b. Tir	ne of 28c. Injury at		ow injury occurred	(Home
	ting Afte fune	tion	1 Stratural 5 ☐ Pending (Month, Day Year) Inj 2 ☐ Accident investigation	ıry Work? M 1 ☐ Yes 2 ☐ No			
Division	Attending r death. ector; After by the fune	ertification:	3 Suicide 6 Could not be	n, street, factory, office	28f. Location (St City or Town	treet and Number of	r Rural Route Number,
Div	after Direct	erti	4 Homicide building, etc. (Specify)		0.0, 0.0	,,	
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, 2 Medical Exeminer: On the basis of examination and and manner stated.	death occurred at the time, date and plac or investigation, in my opinion, death occ	urred at the time, o	late and place, and	dde to the cadse(s)
	Fo the Fo the Fo the Somple	₹ E	29b. Signature and title of certifier	29c. License number	4	29d. Date signed (M	lonth, Day, Year)
			I dale you my	200450	01	10	0000
5F	1-10		30. Name and address of person who completed cause of death (Item 23a) (TSHAHAS ZNOMA 194)	ype. Print) Ceiler 86	uf	Me Hay	eMD21742
Í		tate	31. Date filed (Month, Day, Year) OCT 18 2005 32. Registrar's Signature	South	0	O	
	riegis	Arui	purpose 10.	7			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

**Physician** IRSULA NOVOTN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Easton
If Under 1 Year | If Under 24 Hrs. Memorial 8. Date of Birth (Month, Day, Year)
OCT 21, 19 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1□M 2**X**F 200-24-7298 Yrs. 72 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar must by notified at Director TALBOT CORDOVA 10e. Street and Number 10f. Zip Code 21625 11978 BLADES ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ģ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, tra Ma Elementary/Secondary (0-12) College (1-4or 5+) EXECUTIVE SECRETARY 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ROSE ZOLNOWSHA JOSEPH GENDASZEK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANCIS T. STEVENSON/SON 11978 BLADES ROAD, CORDOVA, MD 21625 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR 10/22/2005 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses FELLOWS, A HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST. EASTON, MD 21601 YOHO X MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition PNEUM ONIA

Due to (or as a consequence of): Physician resulting in death) /Medical Examiner RENAL +CUTE FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit VASCULITIS AUTOIMMUNE and Due to (or as a consequence of): Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? jo 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown ል Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 8 ARTERY 1 Tyes Completed COAGULDPA THY 24a. Was an performed certificate HYPERTENSION 2 No Division of Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 □ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3□ DOA filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: Attending 1 XNatural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide ò 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the F 29b. Signature and title of certifier 29c. License number forse 30. Name and address of persoft who completed cause of death (Item 23a) (Type, Print) HOSPITAL. MEMORIAL DR. OBAYOMI

1. Decedent's Name (First, Middle, Last)

1320 14 2005 4c. County of Death Talbot Birthplace (State or Foreign Country) PA 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: WHITE 16b. Kind of Business/Industry MANUFACTURING 20c. Location - City or Town, State Approximate Interval Between Onset and Death MONTH MONII 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 219 S NASHINGTON ST EASTON, MD 21601

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

OCT 1 9 2005

. Registrar's Signature

n	.51		State of Maryland / D  State of Maryland / D  State of Maryland / D  Registrar	epartment of line G850 12- Certificate of	Health and N 13-05 tas Death	Mental Hyg	iene 2005	35104
1	Physici	ian	1. Decedent's Name (First, Middle, Last)			2. Date of Deat Month October		3. Time of Death
100	/Medi		Joshua Nazareth  4a. Facility Name (If not institution, give street and number)	4h City Town	or Location of Death		4c. County of Deat	
E-	Examir	ier	Shady Grove Adventist Hospital		ckville		Montgome	
9/19	Funeral Director		None	hday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, April 17		hplace (State or Foreign untry) England
	aryland ehow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town	or Location		16-1		10d. Inside City Limits
	Mary a-f eh	tor	Maryland Montgomery Gait	hersburg				1 ☐ Yes 2€ No
	or 28	Director	10e. Street and Number	10f. Zip Code		1	0g. Citizen of What Co	untry?
	eath v		25012 Dunterry Court  11. Marital Status 12. Was Decedent Ever in U.S.	20882			United Kin	
5-0036	filed within 72 hours after death with the Maryland Hygiene this then "natural", or Items 23a or 28a-1 show int, it a Micilical Examiliar must be notified at	by Funeral	1 Never Married 2 Married 1	13. Was Decedent of If Yes, specify Cub		Rican, etc.)	14. Race - Ame Black, White Specify: Eu	9, etc.
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Maryland 2121	d within 72 ho jiene. r then "natur the Medical	du	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retire Student	∍d)	9	Middle Sch	2001
<b>d</b> 2	be filed withintal Hygiene. Id other then		17. Father's Name (First, Middle, Last)	beddene	18. Mother's Nam	e (First, Middle, N		1001
/lan	uld be Mental irked tic ev	To Be	Anthony P. Nazareth		Karen	Francis		
lar,	nd 2 should be fi lith and Menta! I- 27 Is marked ot r traumatic ever	Ċ	19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street	t and Number or Rur	al Route Number,	City or Town, State, 2	ïp Code)
e, P	a a E E		Anthony P. Nazareth - Father 2.20a. Method of Disposition 20b. Place of	5012 Dunter	ry Court,			yland 20882
nor	Pages net of I int: If It			Disposition (Name of control of other plates), Cemeter of Couls Cemeter			20c. Location - City or	
Baltimore,	~ 돈돈을		21. Sign ture of Pineral Service Licensee	22. Name and Addre	ess of Facility		Germantown,	
80	Depermine Deperm		Hovert L. Williams	126401 Rida	ge Road. I	)amaccue.	ineral Home Maryland	20872
	#: 2		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	ot enter the mode of dy	ing, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  Due to (or as a consequence of the control of the cont	f):				
	Examiner							
	be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	f):				
	sicien and burial-transit	Examine	c. Due to (or as a consequence o	<u>f):</u>				
8760,	ate be e hysicier the buri		d					
89	certificat nding phy use as th	Medi	IF FEMALE:					
P.O. Box 6	Attending Physician: The law requires that the death certificate be executed in death.  •ctor: After this certificate hes been signed by the attending physicien and by the itineral director, page 2 should be detached for use as the burial-transit.	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐Ectopic pregnanc 5 ☐ Other (specify) _	.y		23d. Date of deline Month	very Day Year
œ,	ss that gned b	by Pt	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause gr	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ord	w requires I been signe should be					1 ☐ Ye	s 2□No 3□Pro	bably 4 Bunknown
Division of Vital Records,	The law a cate hes be page 2 sh	Completed				24a. Was ar autopsy perform 1 X Yes 2	prior to c ned? d ath?	opsy findings available ompletion of cause of
Vita	tending Physician: Teath. Ior: After this certifical the funeral director, p	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	l Ott	26. Place of Death			
o	y Physer this eral di	<u>ان</u> کو	27 Manner of Death 28a Date of Injury 28b Ti	me of 28c Injur	4 14d13ll1g 110	me 5 Resider	nce 6 Other (Spec	fy)
ion	tending I eath. or; After the funer	atlo	1 Natural 5 Pending 2 Accident investigation  1 Natural 5 Pending 2 Natural 5 Pending 3 Natural 5 Pending 4 Natural 5 Pending 5 Natural 5 Pending 6 Natural 5 Pending				nanged self	
ivis	or Atta	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury At home, fari building, etc. (Specify)			28f. Location (Str. City or Town,	eet and Number of Ru State) 25012	al Route Number, Cour
	To the Hospital or Al within 24 hours after of To the Funeral Direct completely filled in by		Found in residen		(	Saithers	ourg, MD	
	e Hos 24 ho s Fun letely	edical	29a. Certifier  (Check only one)  1 ☐ Certifying Physician: To the best of my knowledge, 2 ☑ Medical Examiner: On the basis of examination and and manner stated.	or investigation, in my of	me, date and place, opinion, death occurr	and due to the ca ed at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the Hospital or Attendi within 24 hours efter death To the Funeral Director: A completely filled in by the fi	Me	29b. Signature and title of certifier	29c. Licens OCM		29	d. Date signed (Month	Day, Year)
			I head the forefames	111	John Chas-		October 22,	
			30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print) LLL P	enn Stree	r palti	more, Mary	Land Z1ZUL
	Sta	ite	31. Date filed (Month, Day, Year) OCT 2 8 2005  12. Figistrar's Signature	A				
)	Registr	ar	00140 ZUUJ	GOONEL				

			For State Registrar		State of M	larylan		rtment tificate				ental Hy	giene Reg. No		,	35105	5
	Physici	an	Decedent's Name (Fi		D-4 11							2. Date of De				3. Time of Death	
	/Medic		Terence Ke					4b. City.	Town, or	Location	of Death	DCIOPON		. County of De		12.2011	
	Examin	er	Doctors Co					•	ham					cince G		ge's	
KENNETH	Funeral Director		5. Social Security Numb 063-22-360	1 1	7. A		last birthday) 75 Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di Jan. 8,	ay, Year)	9. E		ace (State or Forei y) York	ign
3	pu ,		Usual Residence of Dec	cedent													
Z	death with the Maryland me 23a or 28a-f show	ō		<sub>b.County</sub> rince Ge	orge's		y. Town or Lo enbelt								100	d. Inside City Limit  Y Yes 2 □ N	
M	ith the M or 28a-f	Director	10e. Street and Number					10f. Zip	Code				10g. Ci	tizen of What	Countr	ry?	
ENC	23a o	aiD	4A Crescen	t Road					207	770			Uni	ted St	ate	es	
KE	after dea	Funerai	11. Marital Status		12. Was Deceden Armed Forces	?	.S. 13. V	Vas Deced Yes, spec	ent of Hi ify Cuba	spanic Or n, Mexicai	igin? (Spe n, Puerto	cify Yes or N Rican, etc.)	0-	14. Race - Ar Black, W			
7E1	s 1 and 2 should be filed within 72 hours after death with the Maryla Health and Mental Hygiene. Item 27 is marked other than "natural", or Iteme 23a or 28a-1 show other treumatic event, the Medical Examinar insuring a	b	1 ☐ Never Married 3 🔀 Widowed 4 ☐		1 ⊠ Yes 2 □ If Yes, Give Year or Dates			□ Yes X	X No	Specify:				Specify: W	/hit	e	
5-0	"natural",	eted	15. (Specify o	Decedent's Educ	cation completed)		16a. Deced	lent's Usua kind of wor DO NOT us	l Occupa k done d	ation furing mos	it of worki	ng	16b. K	(ind of Busine	ss/indu	ıstry	
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02 Id 2	Hygie other	Be Co	17. Father's Name (Firs					JE		18. <b>M</b> oth	er's Name	(First, Middle					
SC	2 should be filed within and Mental Hygiene.	ToB	Timothy O'	Driscoll						Marg	aret	McCart	hy				
$\int \!$	d 2 shoth and the and the		19a. Informant's Name Michael K.			ı		-					-	or Town, State nton, M		<sup>Code)</sup> rland2111	13
e,	s 1 an f Heal item 2 other		20a. Method of Disposit	tion	·	20b. P	Li Place of Dispo emetery, cren	sition (Nan	ne of			ate		ocation - City			- 0
mo	Page Int: If		1 <b>X</b> Burial 2 □Ci 4 □Donation 5 □		emoval from State	Mar	yland	Veter	ans	Cem.	10/18	3/2005	Ch∈	eltenha	m,M	Maryland	
Salti	permit. Pages 1 and 2 Department of Health a Important: If item 27 le any injury or other tree		21. Signature of Funera	//		1	Do	. Name an	77 E	20201.7	-ra+	Funera	l Ho	ome, PA			
	₫ D 5 € Q		23a. Part1. Enter the dishock, or heart fa	mi	Cuch		44	00 Pc	wder	Mil	l Roa	d Belt	svil	le, Ma	ryl	and 2070	)5
	Physician		shock, o heart fa  Immediate Cause (Fina disease or condition	ilure. List only or	e cause on each	line.		mat		1	20 Ze	no	211631,		i	Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	(	Due to (or a	s a conseq	uence of)	, ,	1						+		
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8760,	icate be ex physician s the buria	dicai			l					··					+-		
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	ne death the atte	Physician/Me	in the past 12 mor 1 ☐ Yes 2 ☐ No	nths?	1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown			Ectopic produced of the second						Month		Day Year	
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Division of Vital Records,	g de	Completed by	Hea	rt 1	allan	2	aking in the di	- Conying o	adob give	J				□No 3□		• /	
900	law requir as been si 2 should	piet										24a. Was	psy	24b. Were	autop:	sy findings availat pletion of cause o	ble of
<u> </u>	sicien: The law certificate has b rector, page 2 s	Con										perf 1 🗆 Yes	órmed? 2♥No	death	1?	2□ No	
Vita	Physicien: this certific al director,	Be	25. Was case referred examiner?	_	lospital:				Othe	200		Check only					
of o	this ald	To :	1 Yes 2 Yolo 27. Manner of Death		28a. Dine of In (Month, D		ER/Outpatien 28b. Time of		8c. Injury	4 L N		ne 5 Res 28d. Describe		6 Other (S	pecify)		
ion	nding Fath. r: After e funer	atior	1 Accident	Pending investigation	(Month, E	lay Year)	Injury	М		k? Yes 2. □	No						
ivis	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6	Could not be determined	28e. Place of I building,	njury - At he etc. (Specif	ome, farm, str	eet, factory	, office			28I. Location City or To			Rural	Route Number,	
۵	Hospitel or 24 hours afte Funeral Dir tely filled in		29a. Certifier	Certifying Phys	sician: To the bes	at of my kno	owledge, death	occurred	at the tim	ne, date a	nd place, a	and due to the	cause(s	and manner	as sta	ted.	
	the Ho hin 24 h the Fui	Medicai	(Check only 2 one)	Medical Examin	ner: On the basis and manner:	of examina	ition and/or in	vestigation	in my of	pinion, dea	ath occurr	ed at the time	, date an	d place, and d	due to t	the cause(s)	
	with To t	2	29b. Signature and title	of certifier				h.	` 7	nedmun e	)		1.1	ate signed (Mo	anth, D	lay, Year)	
	10			2		Laborate 44	- 00-1 7	<u> </u>	L >	- 1			(0/	1210	J	11-	
		ļ.,	30. Name and address	or person who co	ompleted cause of	death (Iten	n 23a) (Type, 77	Print)	361	LE	Poir	IT Dri	ve	Green	, 2e	6-1	
S	St	ate	31. Date liled (Month, I			trar's Signa	ature	alle)	-						7	26770	
1	Regist	rar	00	T 17 20	05	100 1	0.										

			riedse	State of Ma						•		•		
			For State	State of Ma	ii y lai ic			of Death	ATTO TVIC		Reg. No.		( ) Fr 1	00
d <sub>ec</sub>		7 8	1. Decedent's Name (First, Middle, La	ast)				37 B 0 d 1.77	2	2. Date of Dea	ath	000	3. Time	of beating
	Physicia		Zebedee Okwud	ili Oko	v e					Octobe	Day		6:3	5 D M
	/Medic	2	4a. Facility Name (If not institution, given		у С		4b. City, Tov	vn, or Location o	of Death	OCLOBE		County of Deat		J_F
			Southern Marylan	d Hospital	Cent	er	C1	inton			Pı	rince G	eorges	
-	Funeral		5. Social Security Number 6.5			st birthday)	If Under 1 Y Months D	ear If Under 2 ays Hours	24 Hrs. 8 Min. C	B. Date of Birth	h (-Year)	9. Birt	hplace (State juntry) <b>2T1</b> a	or Foreign
. 55	Director		Usual Residence of Decedent	X 23.		Yrs.			C	0/23/19		Nige	eria	
0	A 11		10a. State 10b. County	1	10c. City,	Town or Lo	ocation						10d. Inside	City Limits
Many		ţo	Maryland Montgom	ery	Ger	manto	wn						1 □ Ye	s 2 No
IZIS-0030	r 28a	Funeral Director	10e. Street and Number				10f. Zip Co	de	-		10g. Citi	izen of What Co	untry?	
3	23a c	aiD	19113 Aldenham C	ourt			2	0876			USA	A		
0	ems and	iner	11. Marital Status	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N	Ever in U.S	3. 13.	Was Decedent	of Hispanic Orig Cuban, Mexican	gin? (Spec i, Puerto Ri	ify Yes or No- ican, etc.)		14. Race - Ame Black, White		
9	orit	by Fu	1 Never Married 2 Married	If Yes, Give	10	1	1 □ Yes 2 🗷					Specify: T	Black	
	lura!	o pe	3 Widowed 4 Divorced	Year or Dates:		16a Dece	dent's Usual O	ccupation			16h Ki	ind of Business/		· · · · · · · · · · · · · · · · · · ·
2 5	"na" n	piet	(Specify only highest gr	rade completed)		(Give	kind of work d DO NOT use r	one during most etired)	t of working	7	100.10	10 01 003111033	maastry	
7 7	r tha	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	Phy	ysician				Me	edical		
מוש	othe vsnt,	Bec	17. Father's Name (First, Middle, Las.	t)	·					First, Middle,				
2	Menta Menta rrked	To E	Samson Okoye					Del	borah	Udegb	unen	1		
	and I s me sume		19a. Informant's Name/Relationship			19b. Mailir	ng Address (Si	reet and Numbe	er or Rural i	Route Numbe	r, City o	r Town, State, 2	Zip Code)	
<b>≥</b> , <b>≤</b>	m 27		Ifeyinwa Okoye -	Wife	0.01 51			ham Ct;						
Baitimore	perfilter. Fages i rains. 2 should be in their rains aries been must be may rain perfilter. I have been must be may rain perfect the situation and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avant, it a Medical Examinar must be notified at once.		20a. Method of Disposition 1 A Burial 2 ☐ Cremation 3	ZRemoval from State			osition (Name of matory or other	r place)	Da 11/2/			ocation - City or		
	tent:		4 □Donation 5 □ Other (Speci		Uko	<u>-                                      </u>	npound					os, Nige		
g	mpor mpor my Ir		21. Signature of Funeral Service Lice	insee	$\mathcal{L}$			ddress of Facility						
			23a Part Fotor the disease or con	nolications that caused	the death			ew Hamp				er Spri	ng MD Approxima	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	2				aying, odon do	04101400	. oopnatory an	1031,		Onset and	etween d Death
	hysician /Medical		disease or condition resulting in death)	Due to (or as a		mia							3 4	ه دسک
	xaminer				epsi								2 0	vale,
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a										
	ransii	Examiner	Cause (Disease or injury that initiated events	C										
/ on,	te be executed ysicien and e burial-transit	Ĕ	resulting in death) Last	Due to (or as a	a consequ	ence of):								
		dical	•	d										
o x	e attending phi d for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnan	1CV						004 Data at dat		
0 1	atten	clan	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 4☐Pregnant at	2 Fetal	death 3[	Ectopic pregr				4	23d. Date of del Month	Day	Year
	y the	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□Unknown				//						
Τ .	een signed by the hould be detached	by Pt	Part II. Other significant conditions	contributing to death bu	ut not resu	Iting in the u	nderlying caus	e given in Part I.		23e. Did to	bacco u	ise contribute to	the cause of	death?
cords	n sign									1 🗆 Y	'es 2 (	□No 3□Pr	obably 4	3Unknown
္ပ	as bee	Completed								24a. Was		24b. Were au	topsy finding	s available
r	ate ha	E								autop perfor 1 🗆 Yes	med? 2 □•No	death?	2 □ Mo	cause of
		0	25. Was case referred to medical					26. Place	of Death (	Check only or				
	this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie	nt 2 🗆 8	R/Outpatier	nt 3 DOA	Other: 4 Nu	rsing Hom	e 5 ☐ Resid	lence (	6 □Other (Spec	city)	
	After th		27. Manner of Death  1.☐Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	ry Y Year)	28b. Time o Injury		Injury at Work?		ld. Describe h	ow injur	y occurred		
DIVISION	er death.	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	he			М	1 Yes 2 N						
$\geq$	or All	THE STATE	4 ☐ Homicide determined	d 28e. Place of Inju- building, etc	ury - At hor c. (Specify,	me, farm, sti	reet, factory, of	tice	28	City or Tow	ireet an in, State	d Number or Ru )	ifai Houte Nu	m <i>ber,</i>
-	to this nospital or Attanting raysticant, within 24 hours after death.  To this Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying P	Physicien: To the best of	of my know	vledne deat	h occurred at t	he time, date and	d place an	nd due to the o	Cause/e\	and manner as	stated	
	24 h 24 h Fun etely	edical		aminer: On the basis of and manner sta	examinati									(s)
	routhin Forth	₩	29b. Signature and title of certifier				29c. L	cense number		4	29d. Dat	te signed (Monti	h, Day, Year)	
ľ	7		m Sida	~				1253	65		10	0-06-	200	25
	1		30. Name and address of person who	completed cause of de	eath (Item	23a) (Type,	Print)		1			2 .		
		31	Michael Sida	o completed cause of do	2 11-	70/1	ivings	for R	CO HI	1) ft	WA	ナらんうす	on in	2-76
	Sta		31. Date filed (Month, Day, Year)	2005 32. Augistra	ar's Signat	ure C	parte							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygierie 0 0 5

35107

			1 - For State Ragistrar		Cei	rtificate of l			eg. No.	00107	
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Month			th Day Year	3. Time of Death	
/Medica Examine		cal	4a. Facility Name (Innot institution, give street and number)					10	27 00	5 10,25 mm	
		ner	College View Center			4b. City, Town, or Location of Death Frederick			4c. County of Death Frederick		
	uneral irector		507-01-1627	Sex 1 □ M 2 □ F 88	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 8,	1916 Ne	irthplace (State or Foreign Country) Draska		
land	Health and Men em 27 Is marke ther traumatic		Usual Residence of Decedent  10a. State 10b. County		y, Town or Lo	ocation				10d. Inside City Limits	
э Магу		ctor	Maryland Frede	rick		Fred	derick			tY⊡Yes 2 ☐ No	
th with the		al Director	10e. Street and Number 700 Tollhouse Av	renue		10f. Zip Code	2170		0g. Citizen of What C		
ər dea		Funeral	11. Marital Status	Armed Forces?	12. Was Decedent Ever in U.S. Armed Forces?		Was Decedent of Hispanic Origin? (Specify Yes or Nif Yes, specify Cuban, Mexican, Puerto Rican, etc.)		No- 14. Race - American Indian, Black, White, etc.		
Ours afte		P	1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:		1□Yes 🌠 No	Specify:			White	
<b>1</b> 72 h		Completed	15. Decedent's E (Specify only highest gr	ducation rade completed)	16a. Deced	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of wor	king	16b. Kind of Busines	s/Industry	
Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z		omp	Elementary/Secondary (0-12)	College (1-4or 5+)	1	ts analys			U.S. Gove	ernment	
be filed tal Hyg		Bec	17. Father's Name (First, Middle, Las	t)	·			ne (First, Middle, M	Maiden Surname)		
aryia should b		2	Joseph Solomon	<u> </u>	7			th David			
nd 2 strain			19a. Informant's Name/Relationship Mary E. Keeley/D		3723-	ng Address <i>(Street a</i> 3 Southsi	de B $1 vd.$	, Jackso	, City or Town, State, nville, Fl	zip Code) lordia 32216	
Pages 1 a			20a. Method of Disposition  1 Removal from State Holy Sepulchine Cemetery, crematory or other place)  20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)  4 Donation 5 Other (Specify)								
Dallino Dermit. Pages Department of			21. Signature of Funeral Service Licensee  22. Name and Address of Facility  MOOO21 Keepney & Rasford Funeral Home								
_ 40	within 24 hours after death.  To the Transplace of After death.  To the Funeral Director: After this certificate has been signed by the attending physician and in position of completely filled in by the funeral director, page 2 should be detached for use as the burial-transit of page 2.		23a. Part1. Enter the disease, or complication; that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate Interval Between Onset and Death								
Phy			Immediate Cause (Final								
/M		Н	disease or condition resulting in death)  a. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):								
Exa		<u>.</u>									
6 petro		nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	uence of):							
о о		Examin	that initiated events resulting in death) Last	Due to (or as a consequence of):							
oo / ou, ficate be ex		Medical	d								
Sertific			IF FEMALE: 23b. Was decoded program 23c. If yes, outcome of pregnancy								
O. DO.		Physician	23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No 9  Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	Ectopic pregnancy Other (specify)	•-,,,		23d. Date of de Month	olivery Day Year	
JS, T.		þ	Part II. Other significant conditions contributing to death but not resulting in the us						d tobacco use contribute to the cause of death?		
w requires t		letec	DEMENTIA					24a. Was ar			
The la		Completed						autops perform 1 Yes 2	ned?   death?	autopsy findings available completion of cause of	
VICEI /aician:		To Be	25. Was case referred to medical examiner?  1   Yes   2   No							-ai6.0	
2 g			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28c. Injury at Work?  M 1 \[ \text{Yes} 2 \] \[ \text{No} \]		28d. Describe how injury occurred					
SION Seath.		catlo	2 Accident investigation 3 Suicide 6 Could not the								
UNISION OF tal or Attending Physis after death.		Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)				ation (Street and Number or Rural Route Number, or Town, State)				
Me Hospi		edical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
To th withir	To th	Me	29b. Signature and title of certifier			29c. License	number	29	9d. Date signed (Mon		
	L-		<b>•</b> • • • • • • • • • • • • • • • • • •	T		D-3	31912		10/27/	05	
	10		30. Name and address of person who	completed cause of death (Item			VI Dil	6 GAETE	FILLY m	- 2170/	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture 🖋	DO .	FILE	יוור ואר	IN CILL AN	D 0. 10C	
	Registr	rar	PGT 3 1 200	17 Fis 15%	640004	Elan					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** LOUNGE POWELL SR OCTOBER 2005 7:21P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Montgomery General Hospital Olney If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 9 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Min. , 1924 Hours 1⊠M 2□F Maryland Aug Director 220-12-4102 81 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits show iral', or items 23e or 28a-f shov Examinar must be notified at 1 XYes 2 No Director Silver Spring MD Montgoemry 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1074 Good Hope Road 20809 U.S.A. deeth v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Ses 2 □ No 1943 — If Yes, Give Year or Dates: 1946 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after of Hygiene. Ithar than "natural", or Itel 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "nature and injury or giher traumatic event. If a Michael other. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4or 5+) Guy L. Brown & Son Landscaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Powell Jr Bertha Dorsey 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1074 Good Hope Road Silver Spring, MD 20309 Lounge Powell Jr- Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Ash Mem Cemetery 10/17/05 Sandy Spring, MD 4 Denation 5 ☐ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home, P.A. 21. Signature of Funeral Service Consee 246 N. Washington St Rockville, MD20850 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disa Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician HYPERKALEMIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed MYCCAPIAL Due to (or as a consequence of): physicien ar s the burial-t P.O. Box 68760, Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Tyes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No Certification: To 1 Tes 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation after death.

Pirector: Af
d in by the fur 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours aft To the Funaral Di completely filled in 11 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) the 29b. Signature and titlepof certifier 29d. Date signed (Month, Day Year) 29c. License number SON IA HELMES NO 1026 ( 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOTPRINCEPHILLIP DRUE, OLNEY, MD. 20832 sovia helmes MD 31. Date filed (Month, Day, 32 Registrar's Signature State Registrar

			State of Maryland / Dep CCHD DB CCHD DB CCHD DB 1- State RegistrarAMEND #26 PER PHYS 10/17/05 Ce	artment of Health and	Mental Hygien	2005 35109
			1. Decedent's Name (First, Middle, Last)	Tuncate of Death	2. Date of Death	3. Time of Death
	Physici		Mamie Bergeron Palmer		October	8,2005 11:00 p <sup>M</sup>
	/Medid Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Death
	Exami	Ϋ.	4010 Doncaster Drive	Indian Head		Charles
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	) If Under 1 Year   If Under 24 Hrs Months Days Hours Min.	8. Date of Birth	9. Birthplace (State or Foreign
	Director		229-22-9452 1 M 2 K 82 Yrs.			1923 North Carolin
	and and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Mary -f sh	tor	Maryland Charles Indian	Head		1∭XYes 2☐No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Country?
	h with		401 Bland Drive	20640	τ	J.S.A.
	s I and 2 should be filed within 72 hours after death with the Maryland I Health and Manier Hygiene. I Health and Manier Hygiene. I Health 21 is marked other then, "neturelt, or ttems 23e or 28e-f show other treumatic event, it a Madical Evanciant must be rollified at	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036	urs aft el', or	þ	3 Vidowed 4 Divorced Year or Dates:	1 ☐ Yes 🌠 No Specify:		Specify: White
Š	72 ho	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation	16b.	Kind of Business/Industry
2	ithin ne.	mple	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of wo DO NOT use retired)		••
2	led w lygier her th			Homemaker		er Home
Maryland	ould be filled v Mental Hygie karked other t latic event, it	Be	17. Father's Name (First, Middle, Last) Hubert B. Bergeron	Mary H	me (First, Middle, Maid Ioward	en Sumanie)
Ξ	should lind Men s marke	2		ing Address (Street and Number or R		v or Town. State. Zip Code)
	and 2 sho ealth and n 27 Is m			-		Head, Md. 20640
<u>ი</u>	s 1 and of Health Item 27 other tr		·			Location - City or Town, State
altimore,			N Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify) Oak Dal	osition (Name of or other place) Oct.13 Le Cemetery	3,2005 St	oringhope, N.C.
<u>=</u>	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility		
m —	8989		M00668	Williams Funer	ral Home,	P.A. 20640
п			23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardia	c or respiratory arrest,	proximate Interval Between Onset and Death
	Physician		disease or condition	CAPCER		Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			
		-	Sequentially list conditions, if any leading to immediate b.  Due to (or as a consequence of):			
	nted Insit	mine	cause. Enter Underlying Cause (Disease or injury			
<u>,</u>	exection and ial-tra	Examin	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
8/60,	cate be executed physician and the burial-transit	dical	d			
9	ng ph as th	as t	IF FFMAN C.			
ROX	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of delivery  Month Day Year
Э. Н	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	Physician/M		Other (specify)		William Day 1 Gai
<u>.</u>	res that the de signed by the a be detached t	Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e Did tobaco	co use contribute to the cause of death?
Kecords,	signe d be d	l by	Tartin, Other significant conditions continuing to death out for resulting in the	underlying dause given in Fairti.	1 ☐ Yes	
Ö	v require been st	ompieted			24a. Was an	24b. Were autopsy findings available
Ř	The law cate has I	mp			autopsy performed	prior to completion of cause of death?
Vital	ilcien: Th certificate rector, pag	e Co	25. Was case referred to medical	26. Place of Do	1 ☐ Yes 2 ☐	
5	ysicie s cert direct	0 8	examiner? 1 Yes 2 100 Hospital: 1 Inpatient 2 ER/Outpatient			SCN'S 6 KiOther (Specify) HOUSE
0	g Phy er thi	n: T	27. Manner of Death 28a. Date of Injury 28b. Time		28d. Describe how in	
0	ath. or: Aff	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
Division of	r Atte	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
	itel o urs aff rel Di					
	To the Hospitel or Attending Physicien: within 42 hours after death. To the Funerel Director: After this certifies completely filled in by the funeral director; to the funeral director directors and directors directo	edical	29a. Certifier  (Check only one)  (Check only one)  (Check only one)  (Check only one)	ith occurred at the time, date and place of the convertigation, in my opinion, death occurred.	ce, and due to the cause curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	thin 2 the on the omple	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	F 3 F 8		Marie - MY6H	NIEST	-> 10/1	1/01
Ü			30. Name and address of person who completed cause of death (ttem 23a) (Type	Print)	- "	11)
1	SIN		PO RAY 1702	LaPleto	M) ac	0646
	Sta	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature	4		<del>-</del>
1	Registr	ar	OCT 17 2005	Sneet D		

		1	For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment <i>tificate</i>	of He	ealth a <i>Death</i>	ind Me		iene g. No.	05	351	10
	Physicia /Medic	an	Decedent's Name (First, Middle, Last)     Sarah Frances P	enning	ton					2. Date of Deat Month 10	Day	Year 2005	3. Time of	Death
	Examin		4a. Facility Name (If not institution, give stre Memorial Hospita		aston	4b. City, T Eas	ton					nty of Death bot		
	Funeral Director		211-70-0300	2 <b>X</b> 1F 7. Ag	e (In yrs. last birthday) O Yrs.	If Under 1 Months		If Under 2 Hours	Min.	8. Date of Birth 6-28-	955	9. Births Havr	place (State of	or Foreign Grac
	Maryland f show	tor	Usual Residence of Decedent           10a. State         10b. County           Md         Talbot		10c. City, Town or Lo Easton	cation							0d. Inside C	ity Limits
	3a or 28a	Funeral Director	10e. Street and Number 319 N. Washingto	n St.		10f. Zip (	<sup>Code</sup> 601			1	0g. Citizen USA	of What Cour	ntry?	
036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show than "cate Examiner must be notified a	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒Divorced	Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:	No	Was Decede f Yes, speci 1 ☐ Yes 2	fy Cubar	spanic Origin, Mexican Specify:	gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)	E	Race - Americ Black, White, cify: Whi	etc.	
21215-0036	be filed within 72 hours after death with the Marylan tal Hygiene. d other than "natural", or Items 23a or 28a-1 show event, the Macical Examiner must be notified at	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12) 12 years	ion ompleted) College (1-4or	(Give	dent's Usual kind of work DO NOT use abled	Occupa done di e retired)	tion uring most	of workin	ng		ablec		
and	2 should be filed and Mental Hygid is marked other eumatic event, II	Be	17. Father's Name (First, Middle, Last) George Robert P	enning	ton			0.011		(First, Middle, I				
Maryland	D = V =	To	19a. Informant's Name/Relationship (Type Frances L. Tenna	Print)	19b. Mailir					Route Number				601
Baltimore,	permit. Pages 1 and 2 Depertment of Health Important: If item 27 any injury or other tra		20a. Method of Disposition 1 □ Burial 2 ★Cremation 3 □ Rer 1 □ Donation 5 □ Other (Specify)	noval from State	20b. Place of Dispo cemetery, cre Capitol	sition (Nam matory or ott Cre	e of her place Mate	bry		ate 3-2005	20c. Location	on - City or To	own, State	
Balt	permit. Depertr Importa any inji		21. Signature of Funeral Service Licensee	Hurs	na					Fune			PC 20166	
8760,	Physician and // Medical Examiner physician and physician and physician sit in physician sit in physician sit in physician phy	dicai Examiner	23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as	s a consequence of):	Fack	<u>//</u>	Dese	10	Emp	hysel:	ma	Interval Be Onset and	tween
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		2 Fetal death 3	⊒Ectopic pre ⊒ Other (spe					23d.	Date of defive	-	Year
<u>α</u>	juires that t n signed by ald be deta	by	Part II. Other significant conditions control of Pha Birida	buting to death t	but not resulting in the u	indertying ca	ause grve	n in Part I.		3393	bacco use d es 2□No	ontribute to t		death?  Unknown
Vital Records,		Completed								24a. Was a autops perform	Sy	b. Were auto prior to co death? 1  Yes	mpletion of	
Vita	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	spital: 1 □ Inpati	ient 2 REP/Outpatie	nt 3 DO	A Othe	AC.		(Check only or ne 5 ☐ Resid		Other (Specia	fy)	
ion of	Jing After fune		27. Manner of Death 1	28a. Date of Inj (Month, Da	ury 28b. Time of Injury	of 28	Bc. Injury Work	at ? /es 2 🗀		8d. Describe h	ow injury oc	curred		
Division	ire ire	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In building, e	igury - At home, farm, st tc. <i>(Specify)</i>	reet, factory	, office		2	28f. Location (S City or Tow	treet and Nu n, State)	imber or Rur	al Route Nur	nber,
	To the Hospitel c within 24 hours at To the Funerel D completely filled in	Medical	29a. Certifier (Check only one)  Certifying Physical Examine Medical Examine	r: On the besi and manner s	t of my knowledge, deat of examination and/or in tated.	vestigation,	in my or	oinion, dea	d place, a th occurre	ed at the time, o	ate and pla	ce, and due t	o the cause(	s)
)	To t To t	Σ	29b. Signature and title of certifier	oph.	MP		_	number	128	2	9d. Date sig	ned (Month.	Day, Year)	
(			30. Name and address of person who com Dr. Claude Kopro				+	Oxf	ord	Md 2	1654			
	St Regist	ate rar	31. Date filed (MOC Tay 1 'e2') 2005	3e Cegist	trar's Signature		1	OAL	J_ U,	1100 2				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 24, 2005 **Physician** Jeanette Marie Smith Rosati 6:30pm M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice of Baltimore Towson 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jul 30, 1938 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 M 2 X F 219-26-3543 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits , or Items 23a or 28s-f ehow Maryland Frederick Frederick 1 ☐ Yes 2 📉 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5760 Bartonsville Road 21704 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White þ 3 ☐ Widowed 4 X Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Beautician Hair Stylist 12 is marked other 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fit.
Department of Health and Mental Hy
Important: If Item 27 is marked oth
any injury or other traumatic event 17. Father's Name (First, Middle, Last) Smith Alban Wood Marie Elizabeth Sikorski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Alban W. Smith, Jr - Nephew 4729 Ashforth Way, Owings Mills, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt Olivet Cemetery Oct 28, 2005 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility.
Keeney & Basford P.A. Funeral Home
106 Fast Church Street, Frederick ND 21701 21. Signature of Funeral Service Copsee Deisen M00706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Small cell CANCER Lung Physician jean /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as the ettending phy IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo
9 Unknown Month 4 Pregnant at time of death 5 Other (specify) P.O. F ed by the e 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, β 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 💢 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of pertifier October 25,2005 ey, mo 30. Name and address of person who comple ed cause of death (Item 23a) (Type, Print) les St. Balto. Md 21208 6701 N. Chr 31. Date filed (Month, Day, Year) 32. Registrar's Signature (Tasole) OCT 3 1 2005 Registrar

			For State Registrar	State of Ma	ıryland				lealth Death			giene		5	351	12
			1. Decedent's Name (First, Middle, Last)								2. Date of Dea Month	ath		V	3. Time of	f Death
	Physici /Medic		Eric	Rapp							Octobe	r 16	, 20	Year 05	8:20	$A^{M}$
	Examin		4a. Facility Name (If not institution, give s	treet and number)					r Location	of Death		4c.	County o	of Death		
			Casey House	7.4	- (1			ckvi.		OA Hea			Mont			
	Funeral Director		5. Social Security Number 6. Sex 1区	M 2 F	96	st birthday) Yrs.	Months		Hours	Min.	8. Date of Birth (Month, Day 5/30/1	y. Year)		Cou		or Foreign
	7		Usual Residence of Decedent							1	J/ J0/ 1	<i></i>		Gern	llally	
	Marylan febow	tor	Maryland Montgome	ry		Town or Lo									10d. Inside C	ity Limits
	1 the	Director	10e. Street and Number				10f. Zi	o Code				10g. Citi	izen of W	hat Cou	ntry?	
	th with		8100 Connecticut	Ave.				2081	5			U	SA			
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Importants: if Item 27 is marked other than "nature!", or Items 23a or 28a-f show amy intuments: if Item 27 is marked other than "nature!", or Items 23a or 28a-f show amy intumoration in Items 1 is mailing a special property.	by Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	2. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:		l I	Vas Dece Yes, spe		lispanic Or in, Mexica Specify		ecify Yes or No- Rican, etc.)			, White,		
Ş	2 hour	edt	15. Decedent's Educ	ation		16a. Deced	lent's Usu	al Occup	ation			16b. Ki	ind of Bus		nite	
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<u> </u>	Mould Men Marke	<sup>L</sup>	Albert Rapp								a Darms					
Maryland 21215-0036	alth and 2 st		19a. Informant's Name/Relationship (Type Stanley Junker –								inore M			State, Zij	o Code)	
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를	artme		4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	9	ML.				ery   ss of Facili	ity	7/2005		lphi			
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	Physician /Medical	y, 1),	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	sations that caused e cause on each lin  Septi  Due to (or as a	e. cemia	Do not ente	er the mo	de of dyin	g, such as	SOLIE cardiac c	Ave;	rest,	er Sj	prin	Approximat Interval Bet Onset and	tween
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<u> </u>	Physicien: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	ospital:				104			Check only or					
ō	d is	: To	1 ☐ Yes 2 ☐ No  27. Manner of Death	1 🗆 Inpatier		R/Outpatien 28b. Time of			4 📙 INI		ne 5 Resid				y) Hosp	ice
o	Attending redeath.	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	Year)	Injury	м	28c. Injun Worl	k? Yes 2 □		28d. Describe h	ow injur	/ occurre	ra .		
Divisi	- 9	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	iry - At hon :. (Specify)	ne, farm, stre	eet, factor	y, office		-	28f. Location (S City or Tow	itreet an n, State	d Number	r or Rura	al Route Num	nber,
	To the Hospital or within 24 hours efter to the Funeral Dir completely filled in	edical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of er: On the basis of and manner sta	examination	rledge, death on and/or inv	occurred	at the tin	ne, date ar pinion, dea	nd place, a	and due to the dead at the time, d	ause(s)	and man	ner as s	tated. the cause(s	5)
	To til To til com	Ž	29b. Signature and title of certifier	11/			29	c. Licens	e number			29d. Dat	e signed	(Month,	Day, Year)	
i	10		Call	1//	_		_	D	412	18		te	2/1	6/0	25	
	(		30. Name and address of person who co				,				_			1		
			Charles Harrison 1 31. Date filed (Month, Day, Year)	1.D. 600 32 Registra				_L Rd	; Ro	ckvil	.1e MD 2	:085	2			
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ERICK RAPP

/ bC	,		- State Amend Item 1&Un	State of M pend Ite	aryland/Dep m 23a,27,28 m	artment of F Ba-f per in Intificate of	lealth and ne G849 Death	Mental Hy	giene tas	
	Physici	an	1. Decedent's Name (First, Middle, Last)	-				2. Date of De	ath _	3Tim o De th 3
	/Medic	al	Selina Riley						4, 200!	
	Examin	er	4a. Facility Name (If not institution, give s		1	4b. City, Town, o		ath	4c. County	
	Funeral		5707 Garder Drive  5. Social Security Number 6. Sex		ge (In yrs. last birthday)	Clinto If Under 1 Year	If Under 24 Hr		th	e George's  9. Birthplace (State or Foreign
	Director		UNKNOWN 1 -	M 2 <b>⊠</b> F	Yrs.	Months Days	23'rs Min	oct. 3		Stevenson, Md.
9	pur k		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or L	ocation				10d. Inside City Limits
	Aaryla F sho	ō		07000	Forest					1X Yes 2 No
	28a-	rect	Maryland Prince Ge 10e. Street and Number	orges	rorest	10f. Zip Code			10g. Citizen of V	Vhat Country?
	h with		7009 Kipling Parkw	av		20747			United	States
	items items	Funeral Director		2. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (	(Specify Yes or No		e - American Indian, k, White, etc.
36	or it	by Fu	Never Married 2 Married	1 ☐ Yes 2 ☐ If Yes, Give	No	1 □ Yes 2 🙀 No	Specify:	, , , , , , , , , , , , , , , , , , , ,		Black
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<u>\</u>	should be ind Mental marked o	은	John Sharps, Jr.		12			lle E. Ri		
Maryland	nd 2 shouth and 27 is mur		19a. Informant's Name/Relationship (Type Danielle E. Riley			ng Address <i>(Street</i> 09 Kiplin				
	0 0 E 2	1	20a. Method of Disposition		20b. Place of Dispo		- 1	Date		City or Town, State
Ę	Page net o nt: If ry or	li	1 ☐ Burial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Metropol		, I	.15,2005	Alexand	ria. Va
Baltimore,	permit. Pages 1 Department of H Important: If ite eny Injury or ot once.		21. Signatury of Funeral Service License	•	2	2. Name and Addre	ss of Facility	7/100		
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п			23a. Part . Enter the disease, or complic shock, or heart failure. List only on	ations that cause e cause on each l	d the death. Do not en ine.	ter the mode of dyir	ng, such as cardi	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
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Box (	death certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome					23d Dat	e of delivery
	death e atte	lcla	in the past 12 months? 1 □ Yes 2 🎗 No	4☐Pregnant a		<pre>_Ectopic pregnancy</pre> <pre>_ Other (specify)</pre>	<i>'</i>		Mod	
P.0	that the de led by the a deteched	Physician/M	9 Unknown	9□ Unknown						
	Se pie	ρ	Part II. Other significant conditions con	tributing to death	but not resulting in the u	inderlying cause giv	en in Part I.		V	ibute to the cause of death?
Vital Records,	v requi	Completed						. 10	Yes 2 No	3 ☐ Probably 4 ☐ Unknown
Rec	The law ate hes I page 2 s	ם						24a. Was autor	osy p	Vere autopsy findings available or prior to completion of cause of leath?
<u>a</u>		e Co	25. Was case referred to medical				00 Di	1 🔼 Yes	2 □ No 1	Yes 2□ No
N.	Physicien: this certific ral director.	To B	examiner?	ospital:	ent 2 ☐ ER/Outpatie	nt 3 DOA Oth		eath <i>Check only</i> of Home 5 ☐ Resi		er (Specify) at scene
n of			27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Inj		f 28c. Injur Wor		28d. Describe	how injury occurr	ed Subject Place
Sio	Attending ir death. ector: After by the fune	catle	2 Accident investigation 3 Suicide 6 Could not be	10-4-05	10:00	<b>A</b> M 1 D	Yes 2 No	in Tras	h Can Ar	And Disposed Of ad Storm Drain
Division	i or Attende efter death Director:	Certification;	4 M Homicide determined	building, e	ijury - At home, farm, st tc. <i>(Specify)</i>	reet, factory, office		28f. Location ( City or To	Street and Numb vn, State) 70	Garder Drive
_	ours cours cours cours cours cours		29a. Certifier 1 ☐ Certifying Phys	Scene	of my knowledge, dear	h occurred at the tir	me date and plac	Clinton		nnar ac stated
	To the Hospital or At within 24 hours eftar or To the Funaral Direct completely filled in by	Medical	(Check only 2 X Medical Examinate)	er: On the basis and manner s	of examination and/or in	vestigation, in my o	pinion, death oc	curred at the time,	date and place, a	and due to the cause(s)
	To the within To the comp	ž	29b. Signature and title of certifier	· · · · ·		29c. Licens	e number		29d. Date signed	(Month, Day, Year)
•		Į,	Yamele Trucker	( nu)	anieso a was pro-	0.0	.M.E.		October	5, 2005
0	2	1	1) 1 1 1 1/	mpleted cause of	death (Item 23a) (Type	•	74	D 1	36 -	1 01 001
	Sta	ata	31. Date filed (Month, Day, Year)	82. Regist	rar's Signature	11 Penn S	street,	Baltimor	e, Maryl	and 21201
	Regist		OCT 2 5 2005	Ke .	4 1					

				artment of Health and Men rtificate of Death	tal Hygiene Reg. No. 005 35114
	Physicia	an	1. Decedent's Name (First, Middle, Last)		Date of Death  Anoth  Day  Year
	/Medic	al	Tarleton Danner Rippy  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	tober 13, 2005 5:30 P M
	Examin	er	Civista Medical Center	LaPlata	Charles
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year   If Under 24 Hrs. 8. [	on the of Birth Month, Day, Year)  V. 2, 1933  9. Birthplace (State or Foreign Country)  Washington DC
J.	Director		579-40-2306 71 Yrs. Usual Residence of Decedent	I NC	v. 2, 1933   Washington DC
	arylan show	7	10a. State 10b. County 10c. City, Town or L		10d. Inside City Limits
	tha M 28a-f	Directo	Maryland Charles Wa	aldorf 10f. Zip Code	1 ☐ Yes 2 ☑ No 10g. Citizen of What Country?
	th with	al Di	2005 St. Thomas Drive #309	20602	USA
	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or Items 23a or 28a-f show ont, the Medical Ess of set must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rican	Yes or No- 14. Race - American Indian, n, etc.) Black, White, etc.
036	urs aft	by	1 ☐ Never Married 2 ☐ Married 1 1 ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2X No Specify:	Specify: White
2 2	72 ho	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation a kind of work done during most of working	16b. Kind of Business/Industry
12	within ene. than '	ldmo	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)  Locksmith	Realty
<u>ام</u>	e filed Il Hygi other vent, I	Be C	17. Father's Name (First, Middle, Last)		st, Middle, Maiden Sumame)
Maryland 21215-0036	should be ind Mental s marked o umatic eve	ToE	Benjamin Franklin Rippy		ielding Grigsby
Mar	C1 c0 - c0			ing Address (Street and Number or Rural Ro	
ē,	is 1 and of Health item 27 other to		20a. Method of Disposition 20b. Place of Disposition		809, Waldorf, MD 20602 20c. Location - City or Town, State
Baltimore,	Fr in the		1 LABURAL 2 Ucremation 3 Unemoval from State	Veterans Cem 10-18-	05 Cheltenham, Maryland
Balt	perriti. Pages 1 and Dep riment of Health Important: If item 27 any njury or other tr once.		M01240	2. Name and Address of Facility	P.O. Box 156 Waldorf, MD 20604-0156
I,			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line	iter the mode of dying, such as cardiac or res	piratory arrest, Approximate Interval Between Onset and Death
	Fnysician /Medical	ľ	Immediate Cause (Final disease or condition resulting in death)  a	MI	much
	Examiner		Sequentially list conditions, b. Deallel	to mellits	2004
	pe sit	iner	Fairy, leading to immediate cause. Enter Underlying Cause (Disease or injury	140000	
	execut n and ial-trar	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):		
8760,	ate be executed hysician and the burial-transit	dlcal	d		
9	death certifics attending pl	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		
Box	death certific e attending p id for use as	Physician/Me	in the past 12 months?  1 Vas 2 No 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery  Month Day Year
P.O.	that the d ed by the detached	Phys	9 Unknown		
Ś	es pe pe	b	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown
Vital Record	> 10 0	Completed			24a. Was an 24b. Were autopsy findings available
Ä	The ate h page	Com			autopsy prior to completion of cause of death?  □ Yes 2♥No 1 □ Yes 2 □ No
Vita	Physician: The ribis certificate har all director, page	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	26. Place of Death Ch	
of	는 H	n; To	27. Manner of Death 28a. Date of Injury 28b. Time of	AL Nursing Home	5 Residence 6 Other (Specify)  Describe how injury occurred
sion	Attending in death. sctor: After by the funer	atio	1 X Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	M 1 Yes 2 No	
Division of	l or Attencafter death	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, Iarm, st building, etc. (Specify)	reet, factory, office 28f. L	ocation (Street and Number or Rural Route Number, City or Town, State)
_	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1X Certifying Physician: To the best of my knowledge, deal	th occurred at the time, date and place, and d	lue to the cause(s) and manner as stated.
	To the Ho within 24 To the Fu completel	Medical	(Check only 2 Medical Examiner: Of the basis of examination and/or in and manner stated.		
L	To To	~	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
,			30. Name and address of person who completed cause of death (Item 23a) (Type	D-02975	10-17-05
1	B5?		Daniel M. Howell, MD 11345 Pembroo	k Square, Suite 104,	Waldorf, MD 20603
	Sta Registr		31. Date filed (Month, Day, Year)  OCT 1 7 2005  32. Figistrar's Signature	perti	
		- 4			

State of Maryland / Department of Health and Mental Hygier 🛭 🕦 🖔 35115 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month Thelma Virginia ROHRER October 16, 2005 1:14 p.m. /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Julia Manor Nursing Home Washington Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Funeral Months Days Hours 1 ☐ M 2 💢 F 214-34-9926 Director 67 30. 1937 Maryland Usuel Residence of Decedent Pagas 1 and 2 should be filed within 72 hours after death with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Depertmant of Heelih end Mental Hygiene. Important: If Item 27 is markad other than "natural", or Items 23a or 28a-f shot any injury or other traumatic event, I'm Medical Exactines mast be notiffed at 1 ☐ Yes 2 No by Funeral Director Maryland Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 11403 Stonecroft Court, Apt. 203A 21742 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 ☐ Widowed 4 ☑ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 laundry/linen service hospital 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martin L. Butts Delores Thelma Clipp 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 22521 Cave Hill Road, Smithsburg, Md. 21783 George J. Reichert, III/son 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Boonsboro Cemetery 10/19/05 Boonsboro, Maryland 21. Signature of Eugeral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME (415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Pert1. Enfet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner a 25 for use es the buriel-transit Hospital or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Be Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Tyes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3D DOA this Director: After thi 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Funeral Direct
 Funeral Direct
 Italy filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier within 2 29c. License number 29b. Signature end title of certifier 29d. Date signed (Month, Dey, Yeer) 10/17/05 760396 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) ARID MUR - SHUD 21740

**DHMH 16 Rev 6/95** 

State Registrar

31. Dete filed (Month, Day, Year)

OCT 18

32. Registrar's Signature

**ORIGINAL** 

		For State Registrar	Plea	se Type or Pr State of M		Depa		lealth and N	•		•	35116
Physicia		1. Decedent's Nar		e, Last)					2. Date of D Month	eath Day	Year	3. Time of Death
/Medica		Maria Re				1			Octobe	r II,	2005	1:05 p M
Examine	er	4a. Facility Name 14405 Br		n, give street and number Terrace	(r)		Rockvil	r Location of Death	1		County of Deal	
Funeral Director		5. Social Security None			Age (In yrs. last bi	irthday) Yrs.	If Under 1 Year Months Days		8. Date of Bi (Month, D	irth	9. Bird	thplace (State or Foreign ountry) ador
Pu .		Usual Residence	of Decedent		100 City Town			<u> </u>		-		
e Maryla a-f shov	ctor	MD MD	Montgo	mery	Rockvi		cation					10d. Inside City Limits 1 ☐ Yes 2X No
or 28	Director	10e. Street and N		Т			10f. Zip Code				zen of What Co	ountry?
eath v	Funeral	14405 Br		12 Was Deceder	nt Ever in U.S.	13 V	20853	lispanic Origin? (Sc	necify Ves or N		ıador 14. Race - Ame	ancan Indian
urs after d	þ	1 🔲 Never Ma	rried 2 🛣 Marr 4 □ Divorced	ied 1 ☐ Yes 20	ş? ☑No			lispanic Origin? (S <sub>l</sub> an, Mexican, Puerti Specify: <b>Ecu</b> a		0-	Black, Whit	e, etc.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	Completed	(Spe	ecify only highe.	t's Education st grade completed)  College (1-4c	r 5+)	(Give i life. E	OO NOT use retired	during most of wor	king	16b. Ki	nd of Business/	/Industry
led with the state of the state		17. Father's Name	. (Eimt Middle	( act)	He	omem	aker	10. Mother's No.	o (Final Mindel)	-	Home	
Mental Harked of	To Be	Pedro Re						18. Mother's Nam		e, Malueri	Surrame)	
2 sho		19a. Informant's						and Number or Ru		-		
1 and Health em 27 ther t		Gloria V		- Sister			Briarwo	od Terrac	ce, Rocl		e, Mary	land 20853
Pages nent of int: If it		1 🗆 Burial 🛭		3 ☐Removal from Sta pecify)				itory 10/1	3/2005			, Virginia
permit. Departm Imports any inju		21. Signature of F	Intral Service	Licensee	7	22	Name and Addres	ss of Facility Sin	ple Tr	ibute ville	. Marvl	and 20852
Obveision		Immediate Cause	Final	complications that positions only one cause on sach		not ente	er the mode of dyin				, mary r	Approximate Interval Between Onset and Death
Physician /Medical Examiner		disease or condit resulting in death		Due to (or a	atic Bre as a consequence Breast C	of):						18 months 8 years
	er	Sequentially list of any, leading to	immediate	b	as a consequence							o years
siclan and burial-transit	Examine	Cause (Disease of that initiated even resulting in death	or injury nts	cDue to (or a	as a consequence	of):						
cate be	dlcal			d								
es that the death certificate igned by the atlending phy be detached for use as the	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									ivery Day Year	
	by P	Part II. Other sign	nificant condition	ons contributing to death	but not resulting	in the un	derlying cause giv	en in Part I.				the cause of death?
The law requi	ompleted								24a. Was auto perf 1 Yes		prior to death?	utopsy findings available completion of cause of
ician: Th certificate rector, pag	Bec	25. Was case refr examiner?	erred to medica					26. Place of Dea				
hysic this co	ဂ္	1 ☐ Yes 2		Hospital:			3 DOA Oth	4   Nursing H			Other (Spec	cify)
el or Attending Physis s after death. Il Director: After this or d in by the funeral dire	ertification:	27. Manner of De 1 XNatural 2 Accident	5 🗌 Pendir investi	gation	Day Year)	Time of Injury	28c. Injun Worl	yat k? Yes 2 □ No	28d. Describe	now injury	/ occurred	
al or Att	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural City or Town, State)								ıral Route Number,			
Hospita 4 hours Funera ely fille	ledical C	29a. Certifier (Check only one)	1 Certifyir 2 Medical	ng Physician: To the be Exeminer: On the basis and manner	of examination as	je, death nd/or inv	occurred at the tin estigation, in my o	ne, date and place, pinion, death occur	and due to the	cause(s) , date and	and manner as place, and due	stated. to the cause(s)
To the Hos within 24 h To the Fur completely	Me	29b. Signature	nd title of certifie				29c. Licens			29d. Dat	e signed (Month	h, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

OCT 1 4 2005

30. Name and address of person who completed cause of death (Item 23a) (Type. Print) Ralph V. Boccia, M.D., 6420 Rockledge Drive, Suite 4100, Bethesda, MD, 20817

D269675

October 12, 2005

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

U	-06896	Jan	nes St. John Pleas Amend ite	ens 1,28d 10/17/05,BM	Marylan	InfoRM 19a per ud / Depa	Lini G848	TEnsur 5, 10-31- dealth ar	e All f nd Mei	<b>Copies</b> ntal Hyg	Are I	Legible.	05117
CI	n		For Amend It Registrar AMEND#20b, C,	ems 1,28d 10/17/05,BM	w,MbCo	E,G849	tificate of	Death	2	Pate of Dea	leg No.	105	3. Time of Death
1	Physici	an				mes St	. John			Month	Day		M
	/Medic	al	MICHA 4a. Facility Name (If not institution,			JOHN	4b. City, Town,	or Location of I		ctober		2005 County of Deat	8:35 A "
45	Examin	er	406 Oakton Way	give street and trum	<i>761)</i>				DOUL!				
	Francis			. Sex 7	. Age (In yrs.	iast birthday)	Abingo	If Under 24		Date of Birth	1	Harford 9. Bird	thplace (State or Foreign ountry)
Ŀ	Funeral Director		398-68-2292 Usual Residence of Decedent	1 <b>X</b> ]M 2□F	32	Yrs.	Months Days	Hours	Min. F	EB. 3,	197	73	WISCONSIN
	ours after death with the Maryland rei; or Items 23s or 28s-f show Exertiner mast be notified at	or	10a. State 10b. County	OPD	10c. Cit	ty, Town or Lo	ABINGDON						10d. Inside City Limits 1 ☐ Yes 2 📉 No
	the h	Funeral Director	MD. HARF	OKD			10f. Zip Code				10g. Citiz	zen of What Co	ountry?
	with the or			v				009				U.S.A	•
	ne 2%	era	406 OAKTON WA	12. Was Deced	lent Ever in U	I.S. 13.	Was Decedent of If Yes, specify Cut		n? (Specif	y Yes or No-		14. Race - Ame	erican Indian,
မွှ		F	1 Never Married 2 Marrie	Armed Ford	No		_					Black, Whit Specify: Whi	te, etc. .te
030	hours after urai', or Ite	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dat		05	Yes Z	Specify:M	exica	ın		Specify:	HITE
215-0036	n 72 ho natu	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-	4or 5+\	16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	pation during most o d)	of working		16b. Kir	nd of Business	/Industry
2121	filed within I Hygiene. other then	E O	Cleriotically/Gecondary (G-12)	- <del>1</del>	2		SOLDIER				Ţ	J.S. AR	MY
Maryland	s 1 and 2 should be filed f Health and Mentai Hygi item 27 is marked other other traumatic event, I	Be	17. Father's Name (First, Middle, La	St.	John			18. Mother's	s Name <i>(F</i> NOR	irst, Middle, M.A		Sumame) GORIA	
Z	should be ind Mental imarked i	ဥ	STEPHEN  19a. Informant's Name/Relationshi		III.	19b. Maili	ng Address (Stree	t and Number			-		Zip Code)
Ma	d 2 s Ith an 27 is		19a. Informant's Name/Relationshi LTIKA ST. J	ohn <del>N</del> /WIFE			AKTON WA						
ā,	f Health item 27	1	20a. Method of Disposition	III, WII L	20b. F	Place of Diene	setion (Name of	1	Date			cation - City or	Town, State
D D	00 == = (		1 ☐ Burial 2X☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		tate Soll	lace Cr OUTHPO	matory or other pla ematory RT CREMA	TORY 1	0-17-	-2005	R	enosia,	WI.
Baltimore,	permit. Pag Department important: important: sny injury o		21. Signature of Funeral Service	censee	D	C C	2. Name and Addr HAMBERS	ess of Facility FUNERAL	L HOM	E & CF	REMAT	rorium,	P.A.
	<b>2</b> □ = • <b>0</b>		23a. Part 1. Enter the disease, or c	mercus	M000		801 CLEV					E, MD.2	0737 Approximate
7k	Physician /Medical		shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	a. Han	ch line.								Interval Between Onset and Death
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68	rtifical ng phy as th	Medi	IF FEMALE:										
P.O. Box	The law requires that the death certificate be the bear signed by the attending physicial page 2 should be detached for use as the but	by Physiclan/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 Feta	al death 3	Ectopic pregnand J Other (specify)	су			2	23d. Date of de Month	livery Day Year
	es that the igned by be detact	by Pr	Part II. Other significant condition	s contributing to dea	ath but not res	sulting in the u	inderlying cause g	iven in Part I.				. 1	o the cause of death?
ord	w requir been si should						_		_	1 L Y	'es 2[	_ANO 3∐P	robably 4 Unknown
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ita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?						of Death (	Check only o	пе		
Ž	hysic his o	ို	1 XYes 2 □ No			ER/Outpatie	III JUDON			5 🗆 Resid			ecify) at scene
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sio	death. death. ctor: A / the fu	catl	2. Accident investigation 3 ☐ Suicide 6 ☐ Could no	oct 1	0,2065	8:35		Tes 2. No		Gree		Long elsen	****
Division	al or Attending Physician: s after death. if Director: After this certifica id in by the funeral director, p	Certification:	4 Homicide determin	286. Place	g, etc. (Speci	nome, farm, st ify) ~~e	reet, factory, office	•		City or Tow	m, State,	)	den MD
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	To the I within 2. To the I complet	Mec	29b. Signature and title of certifier	and mann	o. 3(d)(0).		29c. Licer	nse number			29d. Dat	e signed (Mon	th, Day, Year)
			) Josha ?	yeer (	ne		(	O.C.M.E		(	Octo	ber 11,	2005
	9+1		30. Name and address of person w	no completed cau									
1,11			Tasha Zaree	Whera I	. a. r	111 Pe	enn Stree	et, Bal	timor	re, Mai	ry1a:	nd 2120	)1
	St Regist	ate rar	31. Date filed (Month, Day, Year)	2005 Re	gistrar's Sign	ature	wei						

		•	1 - For State RegistraMEND#18perINF1	State of M	laryland	d / Depa <i>Cei</i>	artment rtificate	of H	lealth a D <i>eath</i>	ınd Me	ntal Hyg	giene () (	)5	35118
	Physicia	an	Decedent's Name (First, Middle, Las	it)	Care						Date of Dea Month	Day	Yeer	3. Time of Death 7:55 a M
	/Medic		Edna Gertrude  4a. Facility Name (If not institution, give	Siegrist			4b. City. T	Town, or	Location o		ccoper	12, 2	ty of Death	
	Examin	er	13707 Parkland D		,		Rock						tgome	
	Funeral		5. Social Security Number 6. S	ex 7. A	ge (In yrs. I	ast birthday)	If Under 1	1 Year	If Under 2		. Date of Birth	1	9. Birth	nplace (State or Foreign
	Director		578-26-5792	□ M 2/C3tF	.8	5 Yrs.	Months	Days	Hours	Min.	(Month, Day			vintry)
	pu ,		Usual Residence of Decedent  10a. State 10b. County		100 Cit.	, Town or Lo								10d. Inside City Limits
	anyla shov	2	Maryland Montgom	erv	1	ckvill								1 ☐ Yes 2√☐ No
	188-1	Director	10e. Street and Number		110	CKVIII		0-4-			1.	10g. Citizen of	Mhat Ca	
	with t	급		•			10f. Zip (		_			rog. Citizen of		ond y :
	eath	erai	13707 Parkland D	12. Was Deceden	t Ever in LL	S 13 1		085		nin? (Specif	ty Yes or No-	14 Ba	USA	ncan Indian,
	ter d	Funeral	1 Never Married 2 Married	Armed Forces	i? }No		If Yes, speci	fy Cuba	n, Mexican	, Puerto Rio	ly Yes or No- can, etc.)	Bla	ack, White	
8	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	:		1□Yes 2	. ₩ No	Specity:			Speci	ity: Whi	te
21215-0036	be filed within 72 hours after death with the Maryland ital Hyglene. Id other than "natural", or items 23a or 28a-f show event, the Medical Exactings must be notified at	Completed	15. Decedent's Ed (Specify only highest gra			16a. Dece	dent's Usual kind of work	Occupa	ation	of working		16b. Kind of E	3usiness/l	ndustry
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21	filed w Hygier Ather th	S	8			Caf	eteri	a W		4. 41	7	Public	: Sch	
and	be fill	Be	17. Father's Name (First, Middle, Last)  George Raymond	Gibson					Jan	rs Name (/ ie Edi	na M <del>ac</del>	Maiden Suma 1gruder	me)	
3	2 should be and Mental Is marked or raumatic eve	L P	19a. Informant's Name/Relationship			10h Maili		/Caus sa					- Ctoto 7	To Code)
Maryland	es 1 and 2 should b of Health and Ment of Item 27 Is marked ir other traumatic e		Harold L. Siegri				_					r, City or Towr Marylar		
-	Heal Heal tem 2		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	20b. PI	ace of Dispo	sition (Nam	e of	Ţ	Dat	-	20c. Location		
Baltimore,	ages ant of tr: If it		1X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify			emetery, crei klawn					ober	D - 1		. 229
薑	ortar Injur		21. Signature of Funeral Service Licen		2					17, 1		Home I		Maryland
ñ	permit. Pages 1 a Department of He Important: If item any injury or oth		Varient of	(Yell	ere,									, MD 20901
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause	ed the death						_			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Metast		Carcir	oma o	f +1	he Bla	rabbe				Onset and Death 21 Months
7	/Medical		resulting in death)	a	s a consequ		ioma o	- Cs	TC DI	auder				ZI IIOIICIIS
	Examiner		Sequentially list conditions,	b										
	D 등	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a consequ	иепсе ођ.								
	cate be executed oblysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or a		inner of):							-	
8760,	be ex ician burial			D00 10 (01 a	a consequ	derice or).								
87	physicate sthe	dicai		d										
9 X	certif iding ise as	lan/Me	IF FEMALE:	23c. If yes, outcom	e of pregna	ncy						23d. D.	ate of deli	verv
Вох	death certifica e attending ph id for use as t	clar	23b. Was decedent pregnant in the past 12 months?  1 \sum Yes 2 \sum No	1 ☐ Live birth 4 ☐ Pregnant			Ectopic pre Other (spe					T	lonth	Day Year
0	0 0 0	Physicia	9 Unknown	9□ Unknown										
S, P	requires that the een signed by th hould be detache	by P	Part II. Other significant conditions of	ontributing to death	but not resu	ılting in the u	nderlying ca	use give	en in Part I.		23e. Did to	bacco use cor	tribute to	the cause of death?
ğ	w require been sig should b									_	1 🗆 Y	es 2X No	3 Pro	obably 4 Unknown
Vital Record	aw is b	ompleted									24a. Was a		Were au	topsy findings available completion of cause of
Ä	The law sate has b page 2 sl	E O									perfor	med?	death?	
ita	ician: certifica rector, p	Be C	25. Was case referred to medical examiner?						26. Place	of Death (	Check only or			
of <	diis	၉	1 ☐ Yes 2 🛣 No			ER/Outpatier		_	- (L) 1401	rsing Home	5X Resid	ence 6 □Ot	her (Spec	efy)
			27. Manner of Death  1 X Natural 5 ☐ Pending	28a. Date of In (Month, D	jury Jay Year)	28b. Time of Injury		Bc. Injury Work			d. Describe h	ow injury occu	rred	
sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				М		Yes 2 □ N					18
Division		ertification;	4 ☐ Homicide determined	28e. Place of I	njury - At ho etc. <i>(Specify</i>	me, farm, str ')	eet, factory,	office		281	City or Tow		ber or Hu	ral Route Number,
	Hospital or 24 hours afte Funeral Dir stely filled in	0	29a. Certifier 1X Certifying Ph	ysician: To the bes	at of my know	tseh enhelw	h occurred a	t the tim	ne date and	d place, and	d due to the c	ause(s) and m	anner as	stated
	Hos Fur Tely	edical		niner: On the basis and manner	of examinat									
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	$\wedge$			29c.	License	number		2	29d. Date sign	ed (Month	n. Day, Year)
	8		damel	SLEW	u 111	12		DO'	7285			Octobe	r 13	, 2005
	U		30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Print)							
-			James A. Brown,				76	Dr	ive, I	Rockv:	ille, l	MD 2085	50	
	Sta		31. Date filed (Month, Day, Year)	32. degis	trar's Signat	Type A	sels?							
	Registr	ar	OCT 17 2	.000	Marie I	-								

			1 - For State Registrar	State of N	Maryland / De <i>C</i>	partmer ertificat			and M	lental Hy	gieņe		5 3	351	19
	B1		1. Decedent's Name (First, Middle, Last	")						2. Date of De	eath Day	, ,	'ear	3. Time of	Death
	Physici /Medio		Darinka Satelmaj	er						Octobe				12:00	) A M
	Examin		4a. Fecility Name (If not institution, give	street and number	or)	4b. City,	Town, or	Location o	f Death			County of			
			Elternhaus Assis				ton 1 Year	If Under :	24 Hrs	2 Data of Bir		Howan		(2)	
	Funeral Director			^ M 2 🕮 F   ' '	Age (In yrs. last birthd 91 Yrs	Months	Days	Hours	Min.	8. Date of Bir (Month, Da May 21	$\frac{y}{y}$ , $Y \in ar$		Count	ace (State or try) ria-Hu	-
			Usual Residence of Decedent							1147 21	- ,		1000	110 110	iligal y
	nylan ihow		10a. State 10b. County		10c. City, Town or	Location							10	d. Inside Cit	·
	8a-fs	Director	Maryland Montgo	nery	Silver									1 🗌 Yes	2 ( <u>A</u> No
	with th	D E	10e. Street and Number			10f. Zip					3	izen of Wha	at Count	try?	
	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "neturel", or items 23a or 28a-f show event. I'm Medical Examinar must be notilied at	erai	15323 Valencia S	12. Was Deceder	ot Ever in II S		0905	anania Orie	nin? /Cn	naity Voc or No	USA	14. Race -	Amorica	an Indian	
	iter d	Funerai	1 ☐ Never Married 2 ☐ Married	Armed Force	s?	If Yes, spe	offy Cuba	n, Mexican	, Puerto	ecify Yes or No Rican, etc.)	,		White, 6		
9	urs al	ρ	3 ₩Widowed 4 Divorced	If Yes, Give Year or Date:		1 Tyes	2 <b>∏</b> No	Specify:				Specify:	Whi	te	
- C	72 ho	Completed	15. Decedent's Edi (Specify only highest grad	ucation	16a. De	cedent's Usu ive kind of wo	al Occupa	ation	of worki	'na	16b. Ki	ind of Busin	ness/Ind	ustry	
2	ithin Jan	npie	Elementary/Secondary (0-12)	College (1-4c	life	DO NOT u	se retired	)		,,g					
2	lled w lygier her ti		17. Father's Name (First, Middle, Last)		Hom	emaker		10 Matha	da Nama	(First, Middle		n Hon	ne		
Maryland 21215-0036	ntal the orter of orter	Be										Sumame)			
	permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once.	ဥ	Steven Jankic  19a. Informant's Name/Relationship (T	voe. Print)	19b. M	ailing Address	(Street a			Marunk		r Town Str	ate Zin	Code)	
<u>8</u>	Ith ar 27 is 1 trau		Nikolaus Satelma			-				ver Spr					
<u>ი</u>	f Healifem		20a. Method of Disposition		20b. Place of Di		ne of	1		ate		cation - Ci			
Ë	a u u u u		14 Burial 2 Cremation 3 □I  14 Donation 5 □ Other (Specify)		Chestnu	•		´ 1	ct 1	1, 2005	Un	ion S	Spri	ngs. N	ſΥ
Baltimore,	mit. partm porta porta / inju		21. Signature of Funeral Service Licens	600	0					es-Rina				-	
ñ	89 1 8 8		Myden T.	Klober		11800	New I	lampsl	hire	Ave, S	ilve	r Spi	ing	, MD 2	0904
8760,	ficate be executed  Medical Examiner Is the burial-transit	ai Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only commediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, fary, Isaum at 15 monetate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or ab.	Acute Myocas a consequence of): Arteriosclas a consequence of): Coronary A as a consequence of):	ardial erotic	Infa	arction	on					Approximate Interval Betwoen Stand Day 1 hr 40 yrs	veen leath
68/	ificate g phys	edicai		d		-									
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		2 Fetal death at time of death	3 □Ectopic pi 5 □ Other (sp					2	23d. Date o Month		,	ear
o.	igned by	by Ph	Part II. Other significant conditions co	ntributing to death	but not resulting in th	underlying o	ause give	n in Part I.		23e. Did t	obacco u	se contribu	ute to the	e cause of de	eath?
Sp	quires n sign	d b	Cardiac Arrythmia	a						1 🗆	Yes 2[	□No 3(	Proba	ably 4 ⊟Ua	nknown
Hecords,	The law require sate has been sl page 2 should t	Completed	Angina							24a. Was auto perio 1 🗆 Yes		prio	ir to com	sy findings a apletion of ca	vailable use of
Vital	iclan: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?						of Death	(Check only		1			
Division of \	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification; To	27. Manner of Death  1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Ir (Month, L	njury 2 ER/Outpa Day Year) 28b. Timi Injury - At home, farm,	of 2 y M	8c. Injury Work 1 🔲 \	7 110	No	ne 5 ☐ Resi 28d. Describe 28f. Location (	how injur	y occurred			
Š	al or i	erti	4 Homicide determined	building,	etc. (Specify)	,				City or To	wn, State)	)		,	
	ne Hospita 24 hours ne Funera sletely fille	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the be- iner: On the basis and manner	st of my knowledge, de of examination and/o stated.	eath occurred investigation	at the tim	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s) date and	and manne place, and	er as sta I due to	ited. the cause(s)	
	To the within To the Comp	Ž	29b. Signature and title of certifier	N		290	License	number			29d. Date	e signed (A	Month, D	Day, Year)	
•	1		Koher W	Meis	ue mi	>	D362	246			0cto	ber 1	3,	2005	
			30. Name and address of person who c	ompleted cause o	f death (Item 23a) (Typ	e, Print)									
			Robert W. Olwine	, MD 11	5 Roesler	Rd, Gle	en Bu	rnie	, MD	21060					
	Sta Registi		31. Date filed (Month, Day, Year)  OCT 17 20	32 Regis	strar's Signature	and I									

4	State	30. Name and address of person who completed ca  34. D. TILLSTRECT,  31. Date filed (Month, Day, Year) 32	Registrar's Signature	, Print)			- ( ( ( ( )	20,21,03
To the Hosp within 24 hot To the Fune completely fil	Medical	29a. Certifier  (Check only one)  2 Medical Examiner: On the and maximum and title of certifier  29b. Signature and title of certifier			nion, death occur number	red at the time, o		to the cause(s)
Division To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Atten completely filled in by the funerel	Certification:	3 Suicide 6 Could not be determined 28e. Pla	ce of Injury - At home, farm, sti Iding, etc. (Specify)	reet, factory, office		City or Tow		
on of ding Phy After this funeral d	To B	examiner?  1 Yes 2 No Hospital: 1 1  27. Manner of Death 28a. Dat  1 Natural 5 Pending (Mo	Inpatient 2 ER/Outpatier e of Injury onth, Day Year)  28b. Time o	nt 3 DOA Other:	<b>□</b> Hursing Ho	ome 5 Resid	dence 6 Other (Spectow injury occurred	cify)
	e Completed	25. Was case referred to medical			26. Place of Deal	autop perfor 1 ☐ Yes	prior to death? 2 \( \)	completion of cause of
cords, P w requires that been signed I should be det		Part II. Other significant conditions contributing to	death but not resulting in the u	Inderlying cause given	in Part I.	23e. Did to	an 24b. Were au	obably 4 Unknown
O. BOX 6 the death certifi by the attending ached for use as	by Physician/Med	23b. Was decedent pregnant the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Unknown	gnant at time of death 5 [ nown	Ectopic pregnancy Other (specify)			23d. Date of deli Month	Day Year
18760, cate be executed physician and the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	o (or as a consequence of):					
/Medica Examine		Sequentially list conditions, a any leading to inmediate	o (or as a consequence of):  Hylatania  (or a consequence of):					Chronic.
Physician		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)	caused the death. Do not enteach line.	er the mode of dying,	such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death Chin' C
Baltimol permit. Pages Department of Important: If is any injury or of		21. Signature of Funeral Service (Chensee)	un 16	2. Name and Address 501 Pennsy	<sup>of Facility</sup> Res Lvania A	t Haven ve Hager	Funeral Ch rstown Mary	apel 1and 21742
Heal Heal		20a. Method of Disposition  1 Seurial 2 Cremation 3 Removal from  4 Donation 5 Other (Specify)	20b. Place of Dispo cemetery, cren	esition (Name of matory or other place)		Date	20c. Location - City or THAPERSTOWN	Fown, State
E 6 60	7	19a. Informant's Name/Relationship (Type, Print) Sally Starkey / Daug		,			r, City or Town, State, 2 Pennsylvani	
yland Z buld be filed Mental Hygi arked other atic event, I	Be	17. Father's Name (First, Middle, Last) Orin Lee Henchbarger			8. Mother's Name		Maiden Sumame) 1Ck	
G Z 1 Z 1 D-UUSO filed within 72 hours af Hygiene. other than "netural", or ent, the Medical Exam	Completed	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12)  College	(Give life. L	dent's Usual Occupation kind of work done dur DO NOT use retired) emaker	on <i>ring</i> most of <i>work</i>	ing	Domestic	noustry
Iryland Z1Z15-UUSO should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural; or Items 23a or 28a-1 ahow matic event, the Medical Evant file must be notified at	þ	A mad Partied 1 □ Never Married 2 □ Married 1 □ Yes G Hyes, G Year or	2 No live Dates:	/	Specify:	Rican, etc.)	Specify: Wh	ite
s 23s or	Funeral Director	13023 Pennsylvania Ave	cedent Ever in U.S. 13. V	21742	anic Origin? (Sp		J.S.A.	ican Indian,
the Maryk 28a-f aho	ector	Maryland Washington  10e. Street and Number	Hagerstown	10f. Zip Code			log. Citizen of What Co	1 ☐ Yes 2 No
Director		217-42-9444  Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation		may 3, 1	1914 Feiii	10d. Inside City Limits
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year	f Under 24 Hrs.	8. Date of Birth (Month, Day May 3,	9. Birth ( Year) Con	pplace (State or Foreign intry) sylvania
/Med Exami		4a. Facility Name (If not institution, give street and not Avalon Manor Health Care		4b. City, Town, or Lo			4c. County of Death	1
Physic		1. Decedent's Name (First, Middle, Last)  Doris Henchbarger Seese				Month October	Day Year	11:25 A <sup>M</sup>
		1 - For State Registrar	Cer	tificate of De	eath	R 2. Date of Dear		35120

Physician /Medical Examiner  1. Decedent's Name (First, Middle, Last)  LUCENE SAVACE  2. Date of Death Month LUCENE SAVACE  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	Day Year 320 PM  4c. County of Death
Integrical 4. City Town and position of Death	4c. County of Death
Examiner 44. Facility Name (if not institution, give street and number)	•
Peninsula Regional Medical Center Salisbury	Wicomico
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birthday Month. Days Hours Min. (Month. Days)	
Usual Residence of Decedent	/1924 MD
MD Worcester Ocean City  10e. Street and Number  201 Old Landing Rd.  11. Marital Status  10b. County  10c. City, Town or Location  Ocean City  10f. Zip Code  21842  11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or Note of	10d. Inside City Limits
10a. State 10b. County 10c. City, Town or Location 10c. City, Town or Location 10c. City 10c. Ci	1X Yes 2 No
10f. Zip Code	10g. Citizen of What Country?
201 Old Landing Rd. 21842  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No.	14. Race - American Indian,
MD Worcester Ocean City    106. Street and Number   107. Zip Code   108. Zip Code   108. Zip Code   108. Zip Code   108. Zip Code   21842   11. Marital Status   12. Was Decedent Ever in U.S. Armed Forces?   1 Never Married   20x Married   1 Never Married   20x Married   3 New Married	Black, White, etc.  Specify: White
1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 1 New or Dates: WWII 16a. Decedent's Usual Occupation (Specify only highest grade completed)  1 Never Married 2 Married 3 Widowed 4 Divorced 1 New or Dates: WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  1 Never Married 2 Married 3 Widowed 4 Divorced 1 New or Dates: WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  1 Never Married 2 Married 3 Widowed 4 Divorced 1 New or Dates: WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  1 Never Married 2 Married 3 Widowed 4 Divorced 1 Divorced 1 New or Dates: WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  1 Never Married 2 Married 3 Widowed 4 Divorced 1 Divorced 1 New or Dates: WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  1 Never Married 2 Married 3 Widowed 4 Divorced 1 Divorced 1 New or Dates: WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)  1 Never Married 2 Married 3 Widowed 4 Divorced 1	White  16b. Kind of Business/Industry
(Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)  (Give kind of work done during most of working life. DO NOT use retired)	Too. Tand of Businessaniassary
15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Owner/Operator	Tire Service
15. Decedent's Education  (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Owner/Operator  17. Father's Name (First, Middle, Last)  Julius Savage  Ruth Cohn	Maiden Sumame)
19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number	er, City or Town, State, Zip Code)
Jeanne C. Savage  201 Old Landing Rd. Ocean  202 Method of Disposition  203 Method of Disposition  204 Method of Disposition  205 Place of Disposition (Name of cemetery, crematory or other place)  Date	
	20c. Location - City or Town, State
Cape Henlopen Crem: 10/13/05    Cape Henlopen Crem: 10/13/05	Frankford, DE
m && E & S	MD 21811
23a. Part I. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory an shock, or heart failure. List only one cause of pach line.	rest, Approximate Interval Between Onset and Death
Physician Immediate Cause (Final disease or condition resulting in death)  Amedical Immediate Cause (Final disease or condition resulting in death)  A Superficiency of the consequence	Swees
Examiner	
Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury)	
Due to (or as a consequence of):  if any, leading to immediate cause. Enter Unicertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	
drain by the burial of the bur	
as the	
TF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	23d. Date of delivery  Month Day Year
O g to p to	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	obacco use contribute to the cause of death?
SS and the second of the secon	Yes 2 No 3 Probably 4 Unknown
The law we require the state of	prior to completion of cause of
T la	rmed? death? 2 2 No 1 Yes 2 No
25. Was case referred to medical examiner?  1   Yes   2   No   Hospital:   Impatient   2   ER/Outpatient   3   DOA   Other: 4   Nursing Home   5   Resident   Resident   State   Resident	
O & E D D D D D D D D D D D D D D D D D D	how injury occurred
The first trial 1   Thristorial 2   Accident   Thristorial 2   Accident   Thristorial 3   Thri	2
The state of Directors of Direc	Street and Number or Rural Route Number, wn, State)
Against a little function of the property of the control of the co	
The state of the s	29d. Date signed (Month, Day, Year)
D38353	10/12/2005
C. H. 6tl Seve Des MAYAIS 100 & CAYION ST. SALISBUR	my mo
State Registrar OCT 1 7 2005  State Registrar	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 1 1 5 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** October 16 2005 11:35PM William Recher Shaffer /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number 4b. City. Town, or Location of Death Examiner Williamsport Washington County Homewood nursing Home If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2□ F Yrs. Director 80 220-16-3146 March 19 1925 Maryland with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral, or Items 23a or 28a-f show Examinating the notified at 1 ☐ Yes 2X No Director Maryland Washington Hagerstown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 13406 Cherry Tree Circle 21742 United States Completed by Funeral 12. Was Decedent Ever in U.S. Amed Forces?

1X Yes 2 No 10-1-43

If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 6-14-46 Year or Dates: "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) City Government Housing Manager 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) mit. Pages 1 and 2 should be file partment of Health and Mental Hy portant: If item 27 Is marked oth y injury or other traumatic event Be Edward F. Shaffer Jessie Sneckenberger Shaffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13406 Cherry Tree Circle Hagerstown Maryland 21742 Christine Shaffer (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Rose Hill Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 10-20-05 Hagerstown Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee Muclon 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 41961 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of); the attending physician Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year detached for in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed pe 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 No Certification; To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Director: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide the Funeral 150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title mpleted cause of death (Item 23a) (Type, Print OH ST 100 32. Rebistrar's Signature State 9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend, 31, TCHD, For 10/17/2005, sbbState of Maryland / Department of Health and Mental Hygiene 0 5

Certificate of Death

Reg. No.

	- negistiai		State of Ma		Certii	ficate of	Deain	2. Date of De			3. Time of Death
cian	1. Decedent's Name (First,	, міааів, цазі)	Selb	4				Month / O	Day	2 Pear	1106AM
dical - niner	4a. Facility Name (If not ins	stitution, give s			41		or Location of Death		4c.	County of Dea	ath
	University a	of Mar					imore C			0.5:	
ıl r	5. Social Security Number 221-09-97	149 1×	M 2□F 7. Age	(In yrs. last b		f Under 1 Yea Ionths Days		8. Date of Bir (Month, Da		0	rthplace (State or Foreigr country) DELAWARE
		County		10c. City, To							10d. Inside City Limits 1 X Yes 2 □ No
cto		EEN ANN	Æ, 2	CH	NTREV				10a Citi	zen of What C	
Dire	10e. Street and Number 713 CHURCH	нтіл. Б	GAOS			10f. Zip Code 216			iog. Citi	US	
by Funeral Director	11. Marital Status  1 Never Married 2  3 Widowed 4 Di	☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:			s Decedent of es, specify Cu	Hispanic Origin? (S ban, Mexican, Puert o Specify:	pecify Yes or No Rican, etc.)	)-	14. Race - Am Black, Wh Specify:	
Completed	(Specify only	ecedent's Educ y highest grade	cation completed) College (1-4or 5		(Give kin	nt's Usual Occ nd of work don NOT use reti	e during most of wor	king	16b. Ki	nd of Busines	s/Industry
mo:	Elementary/Secondary (	(0-12)	5+	"	TEAC	HER					L EDUCATION
Be	17. Father's Name (First, I						18. Mother's Nar				
2	IRVING SE		0.1.1	1.4	Die Adelliese	A diductor /Chro	et and Number or Ru	DELLA (			Zin Code)
	19a. Informant's Name/Re			1							, Zip Godo)
	WAYNE S. MI  20a. Method of Disposition		NEPHEW	20b. Place	of Dispositi	on (Name of	CENTREVIL	Date		ocation - City o	or Town, State
	1 Burial 2 ☐ Crer	mation 3 🗆 🗆 🗆	lemoval from State			LD CEM		/18/200	5 CE	TREVIL	LE, MD
	21. Signature of Funeral S		MERC	FROG	3	LOWS,	HELFENBEI RRISON ST	N & NEW	MAM I	UNERAL 21601	HOME PA
	23a. Part1. Enter the dise shock, or heart failu	ease, or compl	ications that caused	the death. D		the mode of d	ying, such as cardia	or respiratory	arrest,		Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition	· · · · ·		nonia							
	resulting in death)		Due to (or as		e of):						
	Sequentially list condition if any, leading to immedia cause. Enter Underlying	ns,	Due to (or as		e of):						
Examine	cause. Enter Underlying Cause (Disease of injury that initiated events										
	resulting in death) Last		Due to (or as	a consequenc	e of):						
edical			u.						F		
by Physician/M	IF FEMALE: 23b. Was decedent pregrin the past 12 month 1 Yes 2 No	nant	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal dea		ctopic pregna Other (s <i>pecify)</i>				23d. Date of d Month	lelivery Day Year
Phy	9 Unknown  Part II. Other significant	canditions co.	ntributing to death h	ut not resultin	n in the und	erlying cause	given in Part I.	23e. Did	tobacco	use contribute	to the cause of death?
	Talt II. Other signmount		~					1 🗆	Yes 2	□No 3□	Probably 4 Unknow
Completed								24a. Wa auto per 1 Yes	opsy formed?	prior t death	
	25. Was case referred to	medical					26. Place of De				
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Be	examiner? 1 ☐ Yes 2 🔼 No	'	29a Date of Inju	ry 28 v Year)	b. Time of Injury	28c. lr V	njury at Vork? □ Yes 2 □ No	28d. Describe	how inju	ry occurred	
To Be	1 ☐ Yes 2 🔼 No 27. Manner of Death	Pending investigation	28a. Date of Inju (Month, Da	, ,							
To Be	1 ☐ Yes 2 ☑No  27. Manner of Death 1 ☑Natural 5 ☐ 2 ☐ Accident	Pending	28e. Place of In		, farm, stree				(Street a		Rural Route Number,
Certification; To Be	1 Yes 2 No  27. Manner of Death  1 Natural  2 Accident  3 Suicide  4 Homicide	Pending investigation Could not be determined	28e. Place of Inbuilding, et	ury - At home c. (Specify) of my knowle f examination	dae, death o	et, factory, office		City or To	own, Stat	e) and manner	as stated.
To Be	1 Yes 2 No  27. Manner of Death  1 Natural  2 Accident  3 Suicide  4 Homicide  29a. Certifier  (Check only 2	Pending investigation Could not be determined Certifying Phy Medical Exam	28e. Place of Inbuilding, el	ury - At home c. (Specify) of my knowle f examination	dae, death o	occurred at the stigation, in m	e time, date and plac	City or To	e cause(s	e) ) and manner d place, and d	as stated.
edicai Certification; To Be	1 Yes 2 No  27. Manner of Death  1 Natural  2 Accident  3 Suicide  4 Homicide  29a. Certifier (Check only one)	Pending investigation Could not be determined Certifying Phy Medical Exam	28e. Place of Inbuilding, el	ury - At home c. (Specify) of my knowle f examination ated.	dge, death o and/or inve	occurred at the stigation, in m	e time, date and plac y opinion, death occ	City or To	e cause(s date an 29d. Da	and manner d place, and d ate signed (Mc	as stated. lue to the cause(s)
edicai Certification: To Be	1 Yes 2 No  27. Manner of Death  1 Natural  2 Accident  3 Suicide  4 Homicide  29a. Certifier (Check only one)	Pending investigation Could not be determined Certifying Phy Medical Exam	28e. Place of Inbuilding, et	ury - At home c. (Specify) of my knowled f examination ated.	dge, death o and/or inve	occurred at the stigation, in m	e time, date and plac y opinion, death occ	City or To	e cause(s date an 29d. Da	and manner d place, and d ate signed (Mc	as stated. lue to the cause(s) onth, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 11:10 P M **Physician** October 15, 2005 Bernard TAUGER /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Mariner Health of Silver Spring Silver Spring 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number New York **Funeral** 1 GM 2□ F 1920 l Yrs. 053-12-1501 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Importent: If item 27 is marked other then "natural; or items 23e or 28e f show entry injury gother traumatic event, the Modical Extentional be redifficed at once. 10a. State 1 ☐ Yes 2 ☐ No Montgomery Silver Spring Maryland 10g. Citizen of What Country? 10e. Street and Number United States 901 Arcola Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Specify: white 1 ☐ Yes 2 XNo Specify: Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced Completed 1 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Certified Public Accountant Accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida (unknown) Philip Tauger ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 701 Falls Grove Dr., #313, Rockville, MD 20850 Doreen Goldberg, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State Beth David Cemetery 10/20/05 Elmont, NY \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service Licensee Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA YJECKS Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records. ALZHEIMERIS 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 2 No 1 Yes Division of Vital the Hospital or Attanding Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner Death Certification: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No after death.

Diractor: Aft investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of Certifier DO 9834 3720 FAFRAGUT AUG. KENSINGTON, MY 20871 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** October 2005 1:48 Mildred M. Thorpe /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Poolesville 19120 Jerusalem Rd. 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🗓 F Director 17, 1930 Maryland Jan. 215-26-1136 Usual Residence of Decedent with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State rei', or itema 23a or 28a-f ehow Examiner must be notified at 1 ☐ Yes 2 X No Directo <u>Poolesville</u> Maryland | Montgomery 10f. Zip Code 10g. Citizen of What Country? 20837 United States 19120 Jerusalem Rd. riit. Pages 1 and 2 should be filed within 72 hours after death variant of Health and Mental Hygiene.
octant: if Item 27 is marked other than "nature!", or itema 23 injury or other traumatic event, the Madical Examinar must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. White Specify: Completed by 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ada M. Testerman Irving M. Moran 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Delbert Thorpe / Husband 19120 Jerusalem Rd., Poolesville, MD 20837 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/17/2005 Frederick Crematory Frederick, Maryland permit.
Departn
Imports
any inju 21. Signature of uneral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the shock or heart failure. List only one cause on each line. Do not inter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last an Examiner Due to (or as a consequence of) requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day į Month Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deaths been signe should be d þ 1 Yes 2 No 3 Probably 4 Wunknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 Yes 2 No To the Hospital or Attending Physician: within 24-hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death | Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 5 Pending 1 Natural М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, faclory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cert 015809 uno 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Pickert, MD 180 TJ Drive, Frederick, MD 21702 31. Date filed (Month, Day, Year) OCT 18 2005 State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 6:40 P M 12 October 2005 Wilhelmina Thorpe /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Takoma Park Montgomery Washington Adventist Hospital 8. Date of Birth (Month, Day, Year, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2X F Hours Yrs. 1940 Maryland 65 Director 213-36-6771 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a State 10b. County 28a-f show the Medical Examiner must be notified at 1 XYes 2 □ No Directo Seat Pleasant Prince George's Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Items 23a or 20743 United States 5735 Bugler St. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, WI hite etc. African filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify þ American 3 ☐ Widowed 4 ☐ Divorced naturel', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygient Importent: if tem 27 is marked other the any injury or other traumatic event, IMA Once. Government Federal Employee 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ezeta Tisdale John Davis 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5735 Bugler St., Seat Pleasant, MD John E. Thorpe/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 10/18/2005 Brentwood, MD 22. Name and Address of Facility Stewart Funeral Home 21. Signatur of Funeral Service Licensee 4001 Benning Rd., N.E. Wash., DC 20019 Approximate Interval Between Onset and Death Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last ding physician and Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 28c. Injury at Work? 27. Manner of Deat 28d. Describe how injury occurred 1 Anatural 2 Accident 5 Pending investigation 1 Tyes 2 No death. hours after deatl unerel Director: 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) δ 4 Homicide filled in within 24 hours a To the Funerel & Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier October 13,2005 18 4 15 HAMWAM ST HORAL HOUSE MOROTER State 7 2005 Registrar

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State Registrar

**DHMH 16 Rev 6/95** 

cal

(Check only

29b. Signature and title of certifier

Kuttner 31. Date filed (Month, Day, Year) 0CT 18 2005

32. Registrar's Signature

and manner stated.

Cynthia Kuttner-Sands MD

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

- Sands no Williamsport Street Silver 154 North Artizan

29c. License number

29d. Date signed (Month, Day, Yeer)

Williamsport Maryland 21795

October 14, 2005

Throckmorton, Irene Baltimore, Maryland 21215-0036

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Division of Vital Records, P.O. Box 68760,	
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		Registrar  1. Decedent's Name (First, Middle, Last)			ortineate of	Death	2. Date of Death	MG. UU5	3. Time of Death
Physici /Medic		Irene Rosa Throc					October	14,2005	5 1020 M
Examin	er_	4a. Facility Name (If not institution, give s Memorial Hos	street and number)	Easto,		C C Cation of Deat	h .	Talbo	1
Funeral Director		5. Social Security Number 6. Sex 175-03-3108	7. Age (	n yrs. iast birthda 92 Yrs.	y) If Under 1 Year Months Days		(Month, Day, Ye	9. Bii O 7. 1913 Pe	rthplace (State or Foreign ountry) ennsylvania
and		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town or	Location				10d. Inside City Limits
with the Marylan a or 28a-1 ehow	tor	MD Talbot		Eastor	<b>i</b>				1 XYes 2 □ No
h the or 28a	Director	10e. Street and Number		Dabeor	10f. Zip Code		10g.	Citizen of What C	ountry?
23a c		700 Port Street			216	501		U.S.A.	
rs after death v	Funerai		12. Was Decedent Eve Armed Forces? 1 \( \text{Yes} \) 2 \( \text{N} \) No	er in U.S. 10	3. Was Decedent of If Yes, specify Cut	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	
72 hours after death with the Maryland natural, or Items 23s or 28s-f show dical Examine 7.00 in critities	þ	1 X Never Married 2  Married 3  Widowed 4  Divorced	1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify: [	White
	Completed	15. Decedent's Educ (Specify only highest grade	cation e completed)	16a. Dec (Gi	cedent's Usual Occu ve kind of work done . DO NOT use retire	pation during most of wo	rking 16b	. Kind of Business	/Industry
	ompi	Elementary/Secondary (0-12)	College (1-4or 5+)			9d)		. 1 . 1 . 0	
be filed ital Hygi od other	Be Co	17. Father's Name (First, Middle, Last)		) SLa	tistian	18. Mother's Na	me (First, Middle, Maid		vernment
	To B	UNKNOWN				UN	KNOWN		
d 2 should the and Men 7 le marke traumatic		19a. Informant's Name/Relationship (Typ	pe, Print)	19b. Ma	iling Address (Stree	t and Number or R	ural Route Number, Ci	ty or Town, State,	Zip Code)
5 <del>2 2 2</del> 2 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5		Mary Catherine Whe	eler/Frien			ourt, Eas	ton, MD 216		
8 5		20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemetery, c	position (Name of rematory or other pla			. Location - City or	
		4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		Woodlawn	Memorial			aston, MI	
permit Depart Import eny Inj		)	MERLE	= 20	Fellows	Helfen	bein and Ne Street, Ea	ewnam Fur	neral Home,PA
1, 1		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused th					ascon, M	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Blotin	1 Page	ma- Ain				Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a c		modia				
W.	er	Sequentially list conditions,	Due to (or as a	VUSUUC	r accio	hen)-			
uted d ansit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Drigh	asia					
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icate be	dical	<b>€</b> d	talaunt !	180					
eath certificate attending phys	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of 1 ☐ Live birth 2					23d. Date of de	livery
e deat the attr	slcia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at tin		B Ectopic pregnand D Other (specify)			Month	Day Year
res that the de signed by the a		Part II. Other significant conditions con	stributing to death but i	not resulting in the	underwing cause a	won in Part I	23e Did tobacc	O use contribute t	o the cause of death?
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e law re has bee	Completed	Corondry as term	disan				24a. Was an	24b. Were a	utopsy findings available
	Сош	0,0					autopsy performed 1 ☐ Yes 2 ☑	? death?	completion of cause of
Physician: Th r this certificate	Be	25. Was case referred to medical examiner?	lospital:		10		ath (Check only one)		
al di:	. To	1 Yes 2 No	1 21 patient 28a. Date of Injury	2 ER/Outpat	ent 3 DUA		fome 5 Residence		ocify)
Attending Physician: or death. ector: After this certifici by the funeral director,	tion	1 ■Natural 5 Pending 2 Accident Investigation	(Month, Day Y	(ear) Injury	Wo	ork? Yes 2 No	20d. Describe now ii	ijury occurred	
Atter or dea octor by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (	- At home, farm,	street, factory, office		28f. Location (Street	and Number or R	ural Route Number,
rs afte	Cer		building, etc. (	3poury)			City or Town, Si	a19)	
To the Hospital or Attending Is within 24 hours after death or to the Funeral Director: After completely filled in by the funer	edicai	29a. Certifier (Check only one)  1 Certifying Phys 2 Medical Examin	sician: To the best of a ner: On the basis of ex and manner state	camination and/or	ath occurred at the t investigation, in my	ime, date and place opinion, death occu	e, and due to the cause urred at the time, date	e(s) and manner a and place, and due	s stated. e to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier	1		29c. Licen	se number	29d.	Date signed (Mon	th, Day, Year)
		barile The	LIMP		DPS	159762	10	114/00	5
$(\mathcal{O}_{i})$		30. Name and address of person who of	mpleted cause of dea	th (Item 23a) (Typ	e, Print)	M			
Sta	te	31. Date filed (Month, Day (1921) 1. 0	20052. Registar's	Signature	V JONI V	السلام			
Registr	-	001 1 0	2003	A.	and .				

Eddie Trujuillo For

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

oc Type of this in black machine into all all all all	pioc / ii o Eog.bio.	
State of Maryland / Department of Health and Menta	Hygiene AAS	351
Certificate of Death	Reg. No.	271

Baltin	nore, I	Mary	and	2121	Baltimore, Maryland 21215-0036					45.			O5- RPI
permit. Pa Departmen Important any injury	permit. Pages 1 and 2 should be filed within 72 hor Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natura any injury or other traumatic event, the Medical Eques.	d 2 shoulk th and Me 7 ie mark traumatik	d be filk	ed within ygiene. ier than "	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 ie marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be contilled at once.	tems 23	with the	Maryla I shov		Funeral* Director	Physici /Medic Examin	1243	-06891 ``
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Division of Vital Records, P.O. Box 68760,

)		1 - For State Registrar		ryland / De	epartment of H Dertificate of I	Death	Reg		35129
Physicia	_	1. Decedent's Name (First, Middle, La Eddy Trujillo	ist)				2. Date of Death October	<sup>9</sup> , 2005 <sup>ar</sup>	3. Time of Death 2220 P M
/Medic Examin	-	4a. Facility Name (If not institution, gir Quintana Street		ıe	4b. City, Town, or Riverdal	r Location of Death .e		4c. County of Deat Prince Ge	
Funeral Director		212-17-2869	Sex 7. Age ( 1120 M 2□F	(In yrs. last birth 24 Yr	Months Davs	if Under 24 Hrs. Hours Min.	(Month, Day, Y	ear) 9. Bird Co 1981 Was	hplace (State or Foreign unitry) hington, DC
Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince	George's	10c. City, Town	or Location aurel				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
h with the 23a or 28a at be notifi	Funeral Director	10e. Street and Number 5807 Maple Terr	ace		10f. Zip Code 20707		10g	. Citizen of What Co	ountry?
urs after deat al', or items ? Examinar mu	by	11. Marital Status  13©Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cuba ↑ Yes 2□ No			14. Race - Ame Black, Whit Specify: Wh	e, etc.
within 72 ho ene. than "natur he Medical	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	Education rade completed) Colfege (1-4or 5+)	)	Decedent's Usual Occup Give kind of work done life. DO NOT use retired andscaper	during most of wor	king	b. Kind of Business elf Emplo	
uld be fited fental Hygi rked other lic event, I	To Be C	17. Father's Name (First, Middle, Las Erasmo Trujillo	t)	1	-		ne (First, Middle, Ma a Rodrigu		
and 2 shou alth and M 127 ie mai er traumai		19a. Informant's Name/Relationship Erasmo Trujillo/			Mailing Address (Street 07 Maple Te		aurel, Ma	ryland 20	707
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or items 23e or 28e-f show any injury of other traumatic event, the Madical Examinar must be notified at one.		20a. Method of Disposition  1 → Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Special Service Lice	eity)	cemetery	Disposition (Name of crematory or other place Heaven Cemete 22 Name and Addre Francis J.	ery 2	per 14,		ing, Maryland
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Physician /Medical Examiner		shock, or hear failure. List onl Immediate Cause (Final disease or condition resulting in death)	y one cause on each line	Э.	+ Would				Interval Between Onset and Death
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sician: The law requirs certificate has been si; irector, page 2 should b	Completed						24a. Was an autopsy performe 1 X Yes 2	prior to death?	utopsy findings available completion of cause of
ysician: is certific director,	To Be (	25. Was case referred to medical examiner?  1X∑ Yes 2 □ No	Hospital: 1 □ Inpatien	nt 2 □ ER/Outi	patient 3 DOA Oth		ath Check only one	ce 6¥1Other (Spe	at scene
ng Ph fter th ineral		27. Manner of Death  1 Natural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day	Year) 28b. Ti	me of jury 28c. Injury Wo		28d. Describe how		+
크 를 들 드	Certification:	3 Suicide 6 Could not determine	building, etc.	al St. E			City or Town,	et and Number or R State) Quick to CUU	enast@
To the Hospital within 24 hours a To the Funeral completely filled	edical		Physicien: To the best of aminer: On the basis of and manner stat	examination and			urred at the time, date	e and place, and du	e to the cause(s)
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X X		30. Name and address of person wh	o completed cause of de		Type, Print) Penn Street	t, Baltim	ore, Mary	land 2120	1
Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registra		forth				
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		•	1 - For State Registrar	State of	f Marylar				ealth a D <i>eath</i>	ind Me	_	gienę Reg. No.	2001	5	3513
	Physicia /Medic	al	Decedent's Name (First, Middle Alexis Ramon     An Facility Name (If not institution	Chavez Ve		z	4b City	Town o	Location of		2. Date of De Month 10	08	200	5	3. Time of Death 5:30 P
	Examin uneral	er	Suburban Hospi 5. Social Security Number	tal 6. Sex	7. Age (In yrs.	last birthday,	If Unde	Bethe	sda If Under 2		B. Date of Birt	1	Montgo	mery	7 e (State or Fore
Di	irector		None Usual Residence of Decedent  10a. State 10b. County	1∰M 2□F	45	Yrs.	Months	Days	Hours	Min.	oct. 19	9, 19	959 V	enez	uela
the Maryla	28a-f eho	Funeral Director	Venezuela  10e. Street and Number			racaib	o Zu	lia p Code				10a. Citi	zen of What		1 X Yes 2 □ 1
ath with	23s or	rai Di	Calle 84 N 3A-	22 Sector	Valle			N	one			Vei	nezue1		
72 hours after death with the Maryland	marked other than "natural", or fleme 23a or 28a-1 show matic event, the Medical Examinar must be multified at	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☒ Divorced	12. Was Dece Armed For 1 □ Yes If Yes, Giv Year or Da	rces? 2[ <b>]</b> No e	J.S. 13.	Was Dece If Yes, spi 1 X Yes		Specify:		ify Yes or No ican, etc.) cueliar		14. Race - A Black, W Specify:	hite, etc	
within 72 ho	than "natur o Medical	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12) 1 2		-4or 5+)		dent's Usi kind of w DO NOT	ork done d use retired				16b. Kii	nd of Busine	ss/Indus	stry
uld be filed v	rked other tic event, II	To Be Co	17. Father's Name (First, Middle, Romelo Chavez	Last)		rei	SOIIII	eT.			First, Middle, Velasqu	Maiden		PIO	/eu
1 and 2 shou	27 is r treu		19a. Informant's Name/Relations Dora Chavez Vel			Mara	caib	o Ver	and Number -22 S ezula		Route Number Valle				
1. Pages 1	Important: If Item eny injury or othe once.		20a. Method of Disposition  1  Burial 2  Cremation  4  Donation 5  Other (S	pecify)	_	Place of Dispo cemetery, cre Benefa Funer	matory or ctor al H	other place a ome	1	Da -18	-2005	Mara	cation - City caibo Vene	Zuli	la
permi	eny ir		21. Signature of Funeral Service  23a. Party Enter the disease, or	Parcha	00	4	217	9th S	t. NW	T	Home, I	gton	, DC 2	0011	
Te be executed XX	hysician and hysician ine burial-transit	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (	or as a consecutive property	quence ol):	, R <sub>0</sub>	<u>l</u> 1/3	acten	emic					nset and Death
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law requires that the	5.8	þ	Part II. Other significant condition	F 8	eath, but not res		ınderlying	cause give	en in Part I.			obacco u Yes 2[		to the o	ause of death?
The The	ate has page 2	Completed			J						24a. Was autop perfo 1 ☐ Yes	rmed?	24b. Were prior to death	o compl	lindings availabletion of cause of
Physicien:	certific rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital:		] ER/Outpatie		OA Oth			Check only o				
in .	or: After this	Certification: To	27. Manner of Death  1 Natural 5 Pendin 2 Accident investig	g 28a. Date ( (Mont) gation	of Injury h, Day Year)	28b. Time of Injury	of M	28c. Injun Worl	7 🗀 1101	28	∋ 5 □ Resid d. Describe			рөсіту)	
5 6	To the Funeral Director: completely filled in by the	i Certifi	4 Homicide determ	ined 286. Place	of Injury - At h	ify)			ne date and		II. Location (S City or Tox	vn, State)			
7 2	hs Fun pletely	edicai	(Check only 2 Medical one)	Examiner: On the ba and mann	asis of examina	ation and/or in	vestigatio	n, in my o	oinion, deatl	h occurred	at the time,	date and	place, and d	ue to the	e cause(s)
Tot	To the	¥	29b. Signature and title of certifie		teven h	ilks		C. License		5			signed (Mo		
	Sta	te	30. Name and address of person Heven Wilks 31. Date filed (Month, Day, Year)	who completed caus  MD 5  32. R	Heven We old death (Item	m 23a) (Type,	Print)	eter	an R	d-	Beth	escl	a Mr	) 3	0814

			1- For State of Maryland / I	Depa <i>Cei</i>	artment of H	ealth a D <i>eath</i>	ınd Mental	Hygier	2005	35131
			Decedent's Name (First, Middle, Last)					of Death		3. Time of Death
	Physici		Robert Woodford				Octo	ber 0	<sup>рау</sup> Үөаг 9 2005	11:24P <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location o			c. County of Dea	
	LAGITITI	CI	Suburban Hospital		Bethesda				Montgome	rv
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bit	rthday)	If Under 1 Year	If Under 2		of Birth	9. Bir	tholace (State or Foreign
	Director		577-52-3913 <sup>1⊠M 2□F</sup> 67	Yrs.	Months Days	Hours	Min. Apri	th, Day, Yea .1 1,	1938 Was	hington, DC
	pc ,		Usual Residence of Decedent							
	show	<u>.</u>	10a. State 10b. County 10c. City, Tow	m or Lo	cation					10d. Inside City Limits
	Ba-f	cto	Maryland Montgomery		Bethesda			· · · · · · · · · · · · · · · · · · ·		1 ☑ Yes 2 ☐ No
	or 2	Director	10e. Street and Number		10f. Zip Code			10g. (	Citizen of What C	ountry?
	ath w		6530 Democracy Boulevard		20817				U.S.A.	
	er de	Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of Hi If Yes, specify Cubai	spanic Orig n, Mexican	gin? (Specify Yes , Puerto Rican, et	or No- c.)	14. Race - Am Black, Whi	
36	hours after death with the Maryland ture!, or Items 23e or 28e-1 show at Extroil or count be notified at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 9 Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:			Specify: W	hite
8	hour tural			Door	dent's Usual Occupa	tion		166	Kind of Business	Industry
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12	with ene.	шc	Elementary/Secondary (0-12) College (1-4or 5+) 5+		Teacher				Educatio	n
0	Hyg Hyg other ent,	Be C	17. Father's Name (First, Middle, Last)			18. Mothe	r's Name (First, A	liddle, Maid	en Sumame)	
Maryland 21215-0036	id be ental ked ic ev	To B	Cornelius Alexander Woodford			(Unk	(nown			
ary.	shound M	-		o. Mailir	ng Address (Street a			Vu <i>mber, Cit</i> j	or Town, State.	Zip Code)
Ξ	nd 2 alth a 27 Is		John E. Palsgrove, Jr/Brother 35	57 N	₩ 94th Te	errace	e. Plant	ation.	Florida	33324
re,	of Head		20a. Method of Disposition 20b. Place of Comments	of Dispo	sition (Name of matory or other place		Date	20c.	Location - City or	Town, State
E	Bage High		1 🗆 Buriai 2 🖾 Cremation 3 🗀 Hemoval from State		coln Crema	·	10/17/0	5 Bre	entwood.	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Importment: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other treumatic event, it is Marical Exactle or national be nutified at anone.		21. Signature of Funeral Service Licenses	22	Name and Address	s of Facility	,			11012
Ö	P P E B		Nancy A. Vercentu	11	INES-RINAI 1800 New I	JDI FU Hampsl	UNERAL H hire Ave	OME, Silv	LNC. Zer Spri	ng, MD 20904
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or hear tentre. List only one cause on each line.							Approximate Interval Between
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	/Medical		disease or condition resulting in death)  Possible Myoca  a. Due to (or as a consequence		tar Ilitar(	CLOIL				
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Вох	eath certific attending p	an/	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy				23d. Date of de Month	livery Day Year
0.	the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	5 [	Other (specify)				11101111	54, 154.
P.(	The law requires that the death certifi ite has been signed by the attending page 2 should be detached for use as		Part II. Other significant conditions contributing to death but not resulting	in the H	nderlying cause awa	on in Part I	230	Did tobacc	n use contribute t	o the cause of death?
JS,	uires t signe Id be c	l by	Tartin Stand Significant Continuents Continuents (O death but not resulting to	11 (110 (1	ilderlying cause give	ni iii r datti.	200			robably 4 Dunknown
oro	w requ been should	etec					_			
Records,	e 2 s	ompieted					24a.	Was an autopsy performed?	prior to	utopsy findings available completion of cause of
H F		S					1 🗆	Yes 2 🔀 i	vo 1 ☐ Yes	2 □ No
Vital	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?  Hospital:		Othe		of Death (Check			-
of	this aldi	L.	1 Tes 22 No 1 Inpatient 22 EA/O	utpatier Time of	IL SLI DON	4 🗆 Nui			6 ☐ Other (Spe jury occurred	ecify)
	ing After unel	ion	1 X Natural 5 ☐ Pending (Month, Day Year)	Injury	Work	? ′es 2.⊟N		CIDO ROW III	lary occurred	-
:S:	eatl or: he	ica	2 Accident investigation 3 Suicide 6 Could not be determined determined 28e. Place of Injury - At home, for	arm str	200			tion (Street	and Number or R	ural Route Number,
Division	or Attend after death Director:	Certification:	4 Homicide determined building, etc. (Specify)	arri, 3(r	set, lactory, office			or Town, Sta		0.2.1.0010.7011001,
_	To the Hospitel or Atti within 24 hours after de To the Funerel Directi completely filled in by ti		29a. Certifier 1 X Certifying Physicien: To the best of my knowledg	e, deatl	h occurred at the tim	e, date and	d place, and due t	o the cause	(s) and manner a	s stated.
	24 h e Fui letely	edicai	(Check only 2 Medical Exeminer: On the basis of examination are one)	nd/or in	vestigation, in my op	inion, deat	h occurred at the	time, date a	nd place, and due	o to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License	number		29d. [	Date signed (Moni	th, Day, Year)
			cuti Votra r	7, 1	D-20	274		0c	tober 9,	2005
-	5		30. Name and address of person who completed cause of death (Item 23a)	(Туре.	Print)					
		9	Kirti Vohra, MD, 7710 Bradley B1	vd,	Bethesda	, Mar	yland 20	817		
	Sta		31. Date filed (Month, Day, Year) OCT 1 7 2005  32 Registrar's Signature	Ro	rete!					
	Registi	ar	OCT 17 2005 Below &	Contract of the Contract of th						

			For State Registrar	State of M	arylan	-	artmen			ind M	lental Hy	giene 0	05	351	32
	Dimeiri		1. Decedent's Name (First, Middle, La	-	,						2. Date of De Month		Year	3. Time of	Death
	Physicia /Medic		MOLY Alv	ing W		<b>Y</b>					Octobe	er 13,	2005	10:25	SA. M
	Examin		4a. Facility Name (If not institution, give		)				Location o				nty of Deatl		
H	Funeral		Springbrook Nursi: 5. Social Security Number 6.5		ge (In yrs. i	last birthday)	If Under	1 Year	Spri	24 Hrs.	8. Date of Bi	rth	ntgom 9. Birtl	ery nplace (State o untry)	r Foreign
	Director		218-30-2801	1 M 2 F	9	93 Yrs.	Months	Days	Hours	Min.	Feb. 13	a <i>y, Year)</i> 3 <b>,</b> 1912	Pen	<sup>untry)</sup> nsylvar	nia
	pu >		Usual Residence of Decedent  10a. State 10b. County		10c Cib	y, Town or Lo	oation							10d. Inside Cit	
	show	ō	Maryland Montgom	2rv	100.00	Silve		i na						1 Tes	
	the N	Directo	10e. Street and Number				10f. Zip					10g. Citizen	of What Co		
	h with	0 18	12325 New Hampsh	ire Avenue	ž			0904				Unite	d Sta	tes	
	deatl	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.	S. 13.			spanic Orig	gin? (Spe	ecify Yes or Ne Rican, etc.)			ican Indian,	
õ	hours after death with the Maryland tural', or Itams 23a or 28a-f show al Examinar must be notified at	by Fu	1 Never Married 2 Marned	1 Yes 2		1	1 □ Yes		Specify:	,	,			White	
2-0036	thin 72 hours after death with the Marylan e. an "naturel", or Itams 23a or 28a-f show Medical Examinar must be notified at	q pa	2. Widowed 4 □ Divorced  15. Decedent's E	Year or Dates:		16a Dece	dent's Usua	A Occupa	tion			16b. Kind o			
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7	er then "	Completed	10		J+j	Waitı	cess					Resta	urant	_	
and	be file ta! Hy d oth event	Be	17. Father's Name (First, Middle, Last Axel Peterson	)					18. Mothe		e (First, Middle	, Maiden Sun		(umle)	
Z	should nd Men marke imatic	우		Time Drive		405 14-15		(0)				Oh T.		(unk)	
Z Z	d 2 st th and 7 Is n treun		19a. Informant's Name/Relationship (William G. Wiley								a <i>l Route Numb</i> Silver			yland20	าดกи
<u>o</u>	s 1 and I Health Item 27 other to		20a. Method of Disposition			Place of Dispo	sition (Nan	ne of			Date	20c. Location			7704
Ë	Pages nert of nrt: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Speci	Removal from State fy)						10/	17/2005	Adelp	hi, M	aryland	Ē
Baitimore,	permit. Pages 1 and 2 shouk Department of Health and Me Importent: If item 27 1s mark any injury or other treumations.		21. Signature of Fundral Service Lice	nsee	1	7 2	2. Name an	d Addres	s of Facility	y ardt	Funera	al Homo	Dλ		
מ	90 E 2 9		1 Juy m	Man	him	/ 44	100 Pa	wder	- мi 1	l Ro	ad Relt	gville	, ra , Mar	yland 2	2070!
			23a. Part1. Enter the disease, or conshock, or beart failure. List only	one cause on each	line.	M. Do not ent	er the mod	e of dying	, such as	cardiac o	or respiratory a	arrest,		Approximate Interval Bets Onset and I	e ween
	Pnysician   /Medical		Immediate Cause (Final disease or condition resulting in death)	a	dra	ncea	e Se	nil	e L	)e ,	nenti	ેંદ		757	-5
	Examiner			Due to (or a	a consequence	uence of):	5	276	000		nen ti			250	× - 5
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as											
	cuted nd ransit	Examiner	that initiated events	С.											
Š,	oe exe cian a urial-l	I Ex	resulting in death) Last	Due to (or as	s a consequ	uence of):									
09/80	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical	•	d											
X b	eath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d.	Date of deli	verv	
POX	death e atter d for u	lciar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic pr Other (sp						Month		Year
5	by the	hys	9 Unknown	9□ Unknown		<del></del>									
	res that the de signed by the a I be detached f	by F	Part II, Other significant conditions			ulting in the u	nderlying c	ause give	n in Part I.			1		the cause of d	
ord	w require been si should I	eted	05/20 p	U - 0517	1							Yes 2 No			Jnknown
Vital Records,	e law has b	Completed	Thorac	ic Fyp	105	`/`\$					24a. Was	s an 24 opsy orm <b>e</b> d?	b. Were au prior to death?	topsy findings a ompletion of ca	available ause of
a		e Co	25. Was case referred to medical	T					00 Pl	-4 D11	1 ☐ Yes	2 3 40		2 No	
	ysician: nis certifica director, I	To Be	examiner?	Hospital:	ient 2 🗆	ER/Outpatier	nt 3 DC	A Othe			n <i>(Check only</i> me 5 ☐ Res		Other (Spec	ufv)	
10[	g Phy ter this		27. Manner of Death	28a. Date of Inj (Month, D		28b. Time o		8c. Injury Work			28d. Describe			.,,,	
201	endin sath. or: Aft he fur	atlo	1 Natural 5 Pending 2 Accident investigation	n	, ,	,	М		es 2□	No					
DIVISION	I or Attending Ph after death. Director: After th I in by the funeral	Certification:	3 Suicide 6 Could not I 4 Homicide determined	28e. Place of If	njury - At ho etc. <i>(Specif</i> )	ome, farm, sti	reet, factory	, office				(Street and Nu wn, State)	mber or Ru	ral Route Num	ber,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying P	hysician: To the bes	t of my kno	udodao daat	h onnumed	at the tim	o date an	d place	and due to the	anung(a) and		ctated	
	24 ho 24 ho Fun etely	edical	(Check only 2 Medical Exa	miner: On the basis and manner s	of examina	tion and/or in	vestigation	, in my op	inion, deat	th occur	ed at the time	, date and plac	e, and due	to the cause(s	:)
	To the To the Complete	Me	29b. Signature and title of pertifier	7-0				. License				29d. Date sig			
	2		IN THE	FI i	Qu.			T	31	00	,	10	1141	os	
	9		30. Name and address of person who	7- /-	/		Print)	250	00-	-00	nvor	Catt.	Dr.	#430	>
			31. Date filed (Month, Day, Year)	JUF Kew	trar's Signa	MD	to a summary	0 ~	901	6e/	4, m)	207	70		
	Sta Registi			2005	ce e	4.	alles								

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Reg. N2 0 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 14, VALERIE LYNN WILHITE 2005 3:10 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2231 Bear Den Road Frederick Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F 49 October 5,1956 New York Director 067-50-7823 Usual Residence of Decedent with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits ral', or Itama 23a or 28a-f ahow Examiner must be notified at 1 X Yes 2 No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2231 Bear Den Road 21701 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 [XYss. 2 □ No If Yes, Give Year or Dates: 1975–78 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours after a Department of Health and Mental Hygiene. Important: If itam 27 Is marked other than "natural", or Itam any injury or other traumatic event, the Medical Examiner's QUES. 1 Never Married 2 X Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Technology Company Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) David Pittsley Barbara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Wilhite / Husband 2231 Bear Den Rd. / Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat'.Cem. NOV.8,2005 Arlington, Virginia 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 23a. Part 1. Eyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, to heart failure. List only one cause on each line. 1621 Opossumtown Pike / Frederick, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Breast **Physician** 2,5 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires thet the death certificate be executed attending physician and I for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No certificete 1 Yes 2 No 1 ☐ Yes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 \ Residence 6 ☐ Other (Specify) 1 Tyes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manne of Death 1 Natural To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 ☐ Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9+WA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Convey 195 Thomas Johnson Dr. / Frederick, Maryland Date filed (Month, Day, Ye 2005

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Registrar

			1 - For State Registrar	State of Maryland /		nent of H			ene	35134
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last)  Alice L. (S.) White 4a. Facility Name (If not institution, give s	2hurst	45	City Town or	Location of Death	2. Date of Death Month October	Day Year 13 2005  4c. County of Death	3. Time of Death 4:53 P M
	Examin Funeral Director	er	Union Hospital  5. Social Security Number 6. Sex		pirthday) If I	Elkton Under 1 Year Inths Days		8. Date of Birth (Month, Day, January		place (State or Foreign intry) GA
	D	tor	Usual Residence of Decedent  10a. State  10b. County  MD  Cecil		wn or Locatio	n		2 artawety		10d. Inside City Limits 1 ☐ Yes 2X No
	ath with the 23s or 28e	<b>Funeral Director</b>	10e. Street and Number  2 Manor Court		10	of. Zip Code 21921			g. Citizen of What Cou	
980	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28e-f show he Medical Examana than Domottled at	by	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1		Decedent of His , specify Cubar es 2 XNo	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh	
21215-0036	d within 72 ho piene. r than "natu the Medical	Completed	15. Decedent's Edur (Specify only highest grade Elementary/Secondary (0-12)		a. Decedent's (Give kind life. DO N		tion uring most of worki	ing	6b. Kind of Business/Ir  Own Home	ndustry
Maryland (	nould be filed d Mental Hyg narked othe natic event,	To Be C	17. Father's Name (First, Middle, Last)  Joseph Henry Spoon  19a. Informant's Name/Relationship (Ty)					Johnson)	aiden Sumame) Spooner	-0-11
	is 1 and 2 slot Health an Itam 27 is 1		Ronald Whitehurst/ 20a. Method of Disposition	/ son 1	47 Smu		d, Rising		City or Town, State, Zij  21911  Oc. Location - City or T	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene Important: If Itam 27 is merked other than "natural; or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examinat must be notified at once.		1 X Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)  21. Signature Funeral Service License	Cedar	Hill 22. Nar	Cemete ne and Address	ty 10-1 s of Facility R.T	. Foard	Baltimore, Funeral Ho g Sun, MD	me, P.A.
103.11	Physician		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the death. Do	o not enter the					2 1 9 1 1 Approximate Interval Between Onset and Death
X	/Medical Examiner	iner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of the consequence of t	e of): e of):					
8760, 1/	death certificate be executed e attending physician and of for use as the burial-transit	Icai Examine	Cause (Liseas, or fifting that initiated events resulting in death) Last	Due to (or as a consequence		,				
P.O. Box 68	that the death certifics led by the attending pt detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown		pic pregnancy er (specify)			23d. Date of deliv Month	ery Day Year
	taw requires that as been signed t 2 should be det	by	Part II. Other significant conditions con	ntributing to death but not resulting	in the underly	ying cause give	n in Part I.		cco use contribute to t	
al Reco	The ate h page	e Completed	25. Was case referred to medical						prior to co death? No 1 Yes	opsy findings available impletion of cause of
Division of Vital Records,	ing Phys	To B	examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	ospital: 1 Inpatient 2 EP/C 28a. Date of Injury (Month, Day Year) 28b.	Outpatient 3 Time of Injury	DOA Othe	4 🗀 Nursing Hor		ce 6 □Other (Specia	(y)
Divisi	irac irac irac	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)				28f. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Examir one)	sician: To the best of my knowledger: On the basis of examination a and manner stated.	ge, death occ and/or investic	urred at the time pation, in my op	e, date and place, a inion, death occurre	and due to the cau ed at the time, dat	se(s) and manner as s e and place, and due to	stated. o the cause(s)
)	2	Σ	29b. Signature and title of certifier  The text List	-MD		29c. License	e 23		d. Date signed (Month, $IC/I4/OS$	
	19		30. Name and address of person who co	impleted cause of death (Item 23a	3 Wes	-t me	eŭ st,		<del></del>	
	Sta Registi		30. Name and address of person who co	005 32. Resistrar's Signature	for	ile				

State of Maryland / Department of Health and Mental Hygien [] [] 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year :15 A M **Physician** Grayson Walter WARRENFELTZ October 16, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 33 West Maple Street Funkstown Washington If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 95 Director 214-09-9397 March 10,1910 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City. Town or Location 10d, Inside City Limits Show item 27 is marked other than "naturel", or Items 23a or 28e-f show other traumatic event, the Modical Examiner must be notified at 1 No Yes 2 No Director Maryland Washington Funkstown 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 33 West Maple Street 21734 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white à 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hyglene. ont: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) engineer railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Sadie Delauter Wade Warrenfeltz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marlin Bachtell - son-in-law 30 West Maple Street, Funkstown, Maryland 217434 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State injury or permit. Page Department of Importent: If any injury or once. Funkstown Cemetery 10/20/05 Funkstown, Maryland <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME -415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each incomplications. Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical use 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 þe 1 Yes 2 No 3 Probably 4 Unknown should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 1 ☐ Yes 2 ☐ No 1□ Yes 2 No Hospital or Attending Physician: ector. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Limisidence 6 Other (Specify) 2 1 ☐ Yes 2 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred completely filled in by the funeral eath 28b. Time of 27. Manne Certification: 1 Matural 5 Pendina 1 ☐ Yes 2 ☐ No s after death. 2 Accident investigation 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of pers death (Item 23a) (Type, JUIL R 3H-6 14410 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1 - For State Registrar		f Maryla	nd / Depa <i>Cei</i>	artmen rtificate			and M	lental Hy	giene Reg. No.	005	35136
	Physici /Medic		1. Decedent's Name (First, Middle Elizabeth F		ı						2. Date of De	123	2 Ở 🗗 5	3. Time of Death 9:30a M
	Examin		4a. Facility Name (If not institution William Hill					Town, or ston	Location o	of Death			County of Death albot	
	Funeral Director		5. Social Security Number 213-18-5626	6. Sex 1 ☐ M 2 【X F	7. Age (In yr: 88	s. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min,	8. Date of Bi 5 — 1 7 —	†°9°1′7	9. Birthp Kent	place (State or Foreign
	aryland show	٦.	Usual Residence of Decedent  10a. State 10b. County  Md Talbo	ot.	10c. C	City, Town or Lo							1	10d. Inside City Limits
	vith the M	Director	10e. Street and Number 501 Dutchmans				10f. Zip	Code 1 6 0 1				-	en of What Cour	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Exaction of the institled at once.	by Funeral	11. Marital Status 1 □ Never Married 2 → Married	12. Was Dec Armed For	2 <b>X</b> 0	į.	Was Deced	ent of His		gin? (Sp i, Puerto	ecify Yes or N Rican, etc.)	0- 1	USA 4. Race - Americ Black, White,	etc.
Baltimore, Maryland 21215-0036	n 72 hours a "natural", c	Completed by	3 Widowed 4 Divorced  15. Deceden (Specify only highe	If Yes, Gi Year or E t's Education st grade completed)	ve Pates:	16a. Dece	dent's Usua kind of wor DO NOT us	I Occupa	Specify: tion uring mos	t of work	ing		Specify:Whi nd of Business/In	
d 212	filed withi Hygiene. Ither than		Elementary/Secondary (0-12)  11 years  17. Father's Name (First, Middle,	College ( 2 ye		1	tmis	tres	s		e (First, Middle			al Service
rylan	hould be d Mental marked o matic eve	To Be	Alonzo Fear	.ns		10h Maili			Cai	rola	Moor	е		0-41
e, Ma	l and 2 si Health an sm 27 is r ther traur		Richard H. V		20h	501			na Numbe ins ]		e, Eas		Md . 2	
timor	Pages tment of h tant: If its jury or of		1 ☐ Burial 2 ☐ X remation 4 ☐ Donation 5 ☐ Other (S	pecify)		apitol	Cre	matc	ory	10-1	14-200	5 D	cation - City or To	De.
Bal	Depar Impor any ir		21. Signature of Funeral Service  23a. Part 1. Enter the disease, or heart failure. List	11 16.	lug	1.0					_		Home,	
8760,	death certificate be executed  Exam  e attending physician and id for use as the burial-transit	dical Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	Jugit III 10,2	equence of):								Inierval Between Onset and Death
P.O. Box 6	death certifi e attending ed for use as	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		oirth 2 □ Fe nant at time of	ital death 3	Ectopic pr					2	3d. Date of deliv	ery Day Year
	es gu		Part II. Other significant condition	ins contributing to d	leath but not re	esulting in the u	nderlying c	ause give	n in Part I	Q I	23e. Did	_		the cause of death?
of Vital Records,	elaw hast je2s	Completed	0st.	coprosis	Si (an		)					ormed2	24b. Were auto prior to co death? 1 □ Yes	opsy findings available ompletion of cause of
f Vital	yslcian: is certific director,	To Be C	25. Was case referred to medida examiner?	Hospital:	Inpatient 2	☐ ER/Outpatier	nt 3 DC	)A Othe		-	1  Yes h (Check only ome 5  Res	one)	Other (Speci	
Division o	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	27. Manner of Death  1 Matural 5 Pendir 2 Accident investi	gation	of Injury th, Day Year)	28b. Time o Injury	f 2	8c. Injury Work 1 🔲 \	at		28d. Describe			
Divi	ital or Att irs after d rat Direct led in by	Certifi	3 Suicide 6 Could determ	ined 289. Place build	ing, etc. (Spe						City or To	own, State)		al Route Number,
	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	ledical	one) 2 Medical		best of my kinasis of examiner stated.	nowledge, deat nation and/or in	vestigation	, in my op	inion, dea	nd place, ith occur	and due to the red at the time	, date and	place, and due t	to the cause(s)
)	To To con	Σ	29b. Signature and title of certifie	Eluco	-D		290	:. License HH	25	87	•	29d. Date	e signed (Month, $13/200$	
ſ	1cc		30 Name and address of person Schill A Schill	who completed cau	555	Zenva		Ba	ston	m	216	01		
	Sta Registr		31. Date filed (Month, Day) ar)	L O 280332. F	Registrar's Sig	nature	Jan Comment	E.						

Wooters

Barbara

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Department of Health a  Certificate of Death	ind Mental H	ygiene Reg. No. 005	35138
			Registrar  1. Decedent's Name (First, Middle, Last)	2. Date of D		3. Time of Death
	Physici /Medic		William Edward Watkins	Octok	Day Year	5 2040 M
	Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Control Combridge		4c. County of Dea	ester
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2	_		
	Director		233-30-5689 15 M 2 F 80 Yrs. Months Days Hours	Feb.	girth Year) 9. Bi 20,1925 Wes	t Virginia
7	pug *		Usual Residence of Decedent         10c. City, Town or Location           10a. State         10b. County			10d. Inside City Limits
2	the Marylar 28a-1 show	tor	MD Dorchester Cambridge			1 XYes 2 □ No
	- 1 the	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	ountry?
2	th with		300 Glenburn Avenue 21613		USA	
1	er death	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Amped Forces?  1 □ Never Married 2 Married   1 Meyer   2 □ No   1 Meyer Married   1 Mey	gin? (Specify Yes or N , Puerto Rican, etc.)	14. Race - Am Black, Wh	
T	Urs aft	þ	3 Widowed 4 Divorced Year or Dates: WWII 1 Yes 2 No Specify:		Specify: W	nite
$\bigcirc$	5-0 72 ho	eted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most	of working	16b. Kind of Business	/Industry
	Ind 21215-0036 (Lind with the filed within 72 hours after death with that Hygiens 23s or dother then "natural", or leams 23s or event, the Medical Examiner must be	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Iffe. DO NOT use retired)  11 mechanic		automoti	<i>v</i> e
1	d 2 filed v Hygie other			r's Name (First, Midd	le, Maiden Sumame)	
75	Maryland 21215-0036 (22 should be filed within 72 hours after death with the M to and Mantal Hygiene. 27 Is marked other then "natural", or Items 23s or 28s-1 treumatic event, the Medical Examiner must be nutilise.	To Be	Walter E. Watkins Opal	l Ballah		
1	iore, Maryla ges 1 and 2 should t of Health and Men if Item 27 is marke or other treumatic		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number			Zip Code)
. ]			William Watkins Jr. son 211 Oakley St., Ca  20a. Method of Disposition (Name of	ambriage,	MD 21613 20c. Location - City o	Town State
77	altimore, mit. Pages 1 at partment of Hea portent: If Item y injury or other		1 Burial 2 Cremation 3 Removal from State	10/14/05	Salisbury	
~	Baltimor permit. Pages Department of I		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	Thomas F	uneral Home	P.A.
3	<b>o</b> 82 E 8 8		Brik. 500 Locust St.,			
7			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a shock, or heart failure. List only one cause on each line.	cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a			2 days
	Examiner	ı	pancreatic cance			3 months
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)  Due to (or as a consequence of):  OCUCO GENIC (1) 5 of	610		= 0:-
	60, be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	12912		oyeas
	\$8760, icate be executed physician and sthe burial-transit	dical E	d			
9	687 rtificate ng physias the	Medi	IF FEMALE:			
	Box ath ce	lan/h	23b. Was decedent pregnant  1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of de Month	elivery Day Year
	O. I the de	Physician/Me	1   Pregnant at time of death 5   Other (specify) 9   Unknown   9   Unknown			
	S, P		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Dio	d tobacco use contribute	o the cause of death?
	ould b	ted	hypertension	1	Yes 2□No 3□F	robably 4 DUnknown
	lecc s law r has be e 2 sh	Completed by		24a. We aul	as an 24b. Were a prior to death?	utopsy findings available completion of cause of
	al F			1 ☐ Yes	2 ØNo 1 ☐ Ye	\$ 2□ No
	Vita sicient certifinacto	o Be	examiner?	of Death (Check only	rone) sidence 6 □Other (Sp.	acifu)
	g Phy ger this	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		e how injury occurred	oony)
	sior endin sath. or: Aft	atlo	2 Accident investigation M 1 Yes 2 N			
	Division of Vital Records, P.O. Box I or Attending Physicien: The law requires that the death cer after death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use	Certification;	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and Number or F own, State)	lural Route Number,
	Division of Vital Records, P.O. Box 6: To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1. ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and	d place, and due to th	e cause(s) and manner a	s stated.
	the Ho iin 24 the Fu	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deat and manner stated.	th occurred at the time		
	with Con	2	29b. Signature and title of certifier  29c. License number	AG73	29d. Date signed (Mor	(III, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	9973	10/14/0	9
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patricia Johnson 100 Bramble Street	- Cambri	dge, MO	21613
		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature		, , , , , , , , , , , , , , , , , , , ,	
	Regist	rar	OCT 1 7 2005			

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Wilson 1832 seorge 10 2005 /Medical 4a. Facility Name It not institution, give street and number), University of Maryland Medical Center 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore V/A| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) | Hours | Min. | OCt. | 7.7 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 214-70-569 112M 2□F Director Marylano Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23a or 28a-f ehow the Medical Exempler must be notified at 1 Yes 2 No Director Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21601 2925 Oak Way Funerai Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-!f Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. t 1. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 Yes 21 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygient Important: If tem 27 is marked other the eny injury or other treumatic event. Limit 2006. City Government Lawyer 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Wilson George William Gracie Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 202 Locust St. St. Michaels, Maryland 21663 Wilson Gracie 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Chas thomas Cenetery / 22. Name and Address of Facility 10/17/05 Stimichaels, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatore of Funeral Service Licensee Henry Funeral Home, P. A.

Sio Washington St. Cambridge, Maryland 2/6/3

23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Immediate Cause (Final disease or condition resulting in death) Intracerebral nemorrhage **Physician** 48 hours /Medical Due to (or as a consequence of): Examiner hypertension Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 XNo 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? res 2 No 1 Yes 2 No 1 ☐ Yes To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 15966 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOILY TOILE S. Gréene Baltimore, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			1 = For Amend Items Registrar	25,26,27	per br	Cel	849°119'01' tificate of L	<b>705dhb</b> a w Death	ientai Hy	gien Reg. N	EU (	15	35141
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	/Medic Examin		4a. Fecility Name (If not institution, give	street and number)			4b. City, Town, or	Location of Death		4	c. County	of Death	
15			JOHNS HOPKINS BAY	VIEW MED	CALCEN	TEC		more					
	Funeral		5. Social Security Number 6. Sec	7.Age M 2⊠F	(In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y, Yea	r)	9. Birthpi Count	ace (State or Foreign
	Director		219-12-7855 Usuel Residence of Decedent		02				APR 16	19	23		NC
	yland		10a. State 10b. County		10c. City, Tow	m or Lo	cation					10	d. Inside City Limits
	a-f-e	ctor	MD N/A		Balti	more	9						1  Yes 2 No
	or 28	Director	10e. Street and Number				10f. Zip Code	_		10g. C		What Count	try?
	ath w	-ra	2540 Ashland Ave			140	21205				USA	ce - America	an Indian
	Hem Hem	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ No.		13.	Was Decedent of His If Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	) <del>-</del>		ck, White,	
336	urs af	by F	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:	7.		1 ☐ Yes 2 💢 No	Specify:			Specif	y: Bla	ck
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Maryland	2 should and Men ie marke aumatic	ဥ	19a. Informant's Name/Relationship (T)				ng Address (Street a					State, Zip	Code)
	and 2 s lealth ar m 27 is her trau		Michael Allen-El	- son	2	540	Ashland A	Avenue, E	Baltimon	œ,	MD	21205	
Je,	of Head of Head fitem		20a. Method of Disposition		20b. Place o	of Dispo	sition (Name of matory or other place	9)	Date	20c.	Location -	- City or To	wn, State
Ĕ	Pages nent of I ant: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Baltin	pre	National Ce	met. 10/3	31/2005	F	Balti	more,	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other fraumatic event. Its Medical Examinating mention any once.	İ	21. Signature of Funeral Service Licens		M20006	Č.	FA, Steph	es of Facility	hrmann.	. PA	1		
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	res that igned b	by P	Part II. Other significant conditions co	•	_			en in Part I.	23e. Did	tobacco	use con		e cause of death?
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<b>Division</b>	i or Attend after death Director: .	ifica	3 Suicide 6 Could not be	28e. Place of Inju	ry - At home, f	arm, sti	reet, factory, office	-	28f. Location (	Street	and Numi	ber or Rura	l Route Number,
á	s after s after af Direct	Certification:	4 ☐ Homicide determined	building, etc.	. (Ѕреспу)				Only of 70	Ste	10)		
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: Atter this certificate ha completely filled in by the funeral director, page	edical (	(Check only 2 Medical Exam	sician: To the best o									
	To the H within 24 To the F complete	Medi	one)	and manner stat			29c. License					ed (Month,	
	To To Con		29b. Signature and title of certifier	m.	1				,	روم. د	ale signe		
	Λ		30. Name and address of person who c					5725	<i></i>	00	TOBE	=2 29	,2005
	7		ELIZABETH MIE					VENUE (	BALTIM	ORE	- mo	212	24
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	A	b. 8						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie 2e 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Adamson 27 2005 Carl actober /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 01ney Montgomery Montgomery General Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth July 15, 1942 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Ohio 279-38-4298 63 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or Itams 23a or 28a-f shov Examiner over be notified at Funeral Director 1 ☐ Yes 2 ☑ No MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2<sup>1120</sup> Goshen Road 20882 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1961-62 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: white Be Completed by 3 Widowed 4 Divorced "natural" the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager Financial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be in nent of Health and Mental ant: If Item 27 is marked o George Milton Adamson Margaret E. H. Pearson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21120 Goshen Rd.Gaithersburg, MD 20882 Margaret Adamson/wife permit. Pages 1 and Department of Health Important: if Item 27 any Injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 10-31-2005 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Rapp Tuneral Cremation Service 933 gist avenue Silver Spring, MD 20910 me1358 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Non Small Cell Cong Concer Physician Metastatic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy been signed by the atter should be deteched for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan autopsy performed? 1□ Yes 1 ☐ Yes → No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After the 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death the 6 Could not be determined 3 Suicide within 24 hours after de To the Funeral Directo completely filled in by ti 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

4

Baltimore, Maryland 21215-0036

Box 68760,

Division of Vital Records, P.O.

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

PaneBa

Drive #327
32 Registrar's Signature

Olney, MD 20832

MDO60335

October 27, 2005

32 Registrar's Signature

			1 - For Stata Registra Amend Item	State of Maryla	nd / Depa	artme <b>(†(05</b> a	nt of He Interpor	ealth and <i>eath</i>		gien2 0	05	35143
Ж	Physici		Decedent's Name (First, Middle, La	st)	Action		R		2. Date of De. Month OCTOB	Day -	Year 2005	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)			•	ocation of Dea	ıth		ity of Death	11.00
100		12.00	(1777	HOSPITAL	in a hint of	lilla	BAL br 1 Year	If Under 24 Hr				
124.	Funeral Director		5. Social Security Number 6. S 215-46-8669	1 M 2 F 8	. iast birthday) 7 Yrs.	Month		Hours Mir	. (Month, Da	y, Year)	Coun	
	ס		Usual Residence of Decedent						Jan 1,	1918	Gern	
	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do ther than "natural", or items 23a or 28a-f show do other than "natural", or items 23a or 28a-f show event, the Madical Examinar must be notified at	Funeral Director	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits  MD Anne Arunde1 Pasadena 1 □ Yes 2√2 No									
			MD Anne Arunde1 Pasadena  10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?									
			2531 Mountain Road 21122 USA									
			11. Marital Status	12. Was Decedent Ever in Armed Forces?	J.S. 13.	Was Dec	edent of His	panic Origin? (	Specify Yes or No irto Rican, etc.)		ace - Americ	
36		by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	i	-	2 ₹ No	Specify:	,		//y:whit	
21215-0036	2 hou	To Be Completed h	15. Decedent's E	ducation	16a. Dece	dent's Us	sual Occupat	ion		16b. Kind of	Business/Inc	dustry
215	ithin 7 18. "m 18. "m		(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life.	RING OF V DO NOT	vork done du use retired)	iring most of w	orking			
	filed within Hygiene. other than ent, the Mi		12 17. Father's Name (First, Middle, Last	0	se]	Lf en	nploye		/F:		que st	
anc			17. Father's Name (First, Middle, Last,	)			unk	IB. MOTHERS N	ame (First, Middle,	Maiden Suma	ame)	unk
Maryland	s 1 and 2 should t Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship (	Type, Print)	19b. Maili	ng Addre	ss (Street ar	nd Number or F	Rural Route Numbe	er, City or Tow	n, State, Zip	Code)
	1 and 2 Health a tem 27 is		Karen Hyson/f					s Road	Pasadena	, MD 2	21122	
Baltimore,	iges 1 au it of Hea iff Item or othe		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	Place of Dispo ce <i>metery, crei</i>	natory o	ame of other place,	,	Date	20c. Location	- City or To	wn, State
Itim	permit. Pages 1 Department of H Important: If Ite any injury or ot once.		4 ☐ Donation 5 ☑ Other (Special 21. Signature of Funeral Service Lices	79	20	Namo	and Address	of Equility				
Ba	Departing Departing Important in		Anthony	Pleasant	į.			omy Boa MD 21	rd 655 W	. Balti	Lmore	Street
	- \$ 8		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea						rest,		Approximate Interval Between
E	cate be executed hysician and hysician and physician and the private transit the private transit the private transit that the private transit that the private transit that the private transit that the private transit trans	dical Examiner	Immediate Cause (Final disease or condition		te Ri	ESPI	TRAT	PORY	PADLI	1R. Z	to	Onset and Death
			resulting in death)	Due to (or as a conse	quence of):	12	4	ilna	( 0 - ( )			1
1			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		a. Acute RESPIRATORY PAILUR 2 to Sydays  Due to (or as a consequence of):  Metastatr LUng Cancer -> 7 Month  Due to (or as a consequence of):							
			that initiated events	С								
30,			resulting in death) Last Due to (or as a consequence of):									
8760,			d									
Box (	death certifi e attending p id for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr	23c. If yes, outcome of pregnancy					23d. Date of delivery		
	D O D	Medical Certification: To Be Completed by Physician/Me	in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)				Month Day Year				
P.0	that the de ed by the detached		9 Unknown							23e. Did tobacco use contribute to the cause of death?  12Yes 2 No 3 Probably 4 Unknown		
ds,	eg De		Part II. Other significant conditions (	ns contributing to death but not resulting in the underlying cause given in Part I.								
Sorc	w requir been s should								24a. Was			
Re	The lav								autop perfor	sy med?	prior to con death?	psy findings available inpletion of cause of
			25. Was case referred to medical examiner?					26. Place of De	1 ☐ Yes eath (Check only o	2 No ne)	1 🗆 Yes	2 L No
	hys this		1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						)		
			27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	ry Work?			28d. Describe how injury occurred			
Division			3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Injury - At I	28e. Place of Injury - At home, farm, street, factory, office				28f. Location (S	28f. Location (Street and Number or Rural Route Number.		
-	- 9		building, etc. (Specify)									
	To the Hospital of within 24 hours at To the Funeral D completely filled in		29a. Certifier (Check only one)  29a Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)							ated. the cause(s)		
	o the		one) and manner stated.  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev									
	->+0		Mitirut Get	renoil (mo	D)		RSOO	1				
			30. Name and address of person who	completed cause of death (Ite	m 23a) (Type,	Print)					· 0(')	~~~
pe.			HIRUT GEBREV 31. Date filed (Month, Day, Year)	JULD 3001	Sout	4	HANK	OVER	STREET	BAL	maz	F, MD 21225
	Sta Registr	_	NOV 0 1	2005	alure A	DEAL	8					2005 + , MD 2125

			For State	state of M	laryland Perp				201111	35144	
			1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of							3. Time of Death	
	Physicia /Medic	al		France		,		100nth	2 <sup>5</sup> 2005	4. 12.	
}	Examin	er	4a. Fecility Name (If not institution University Ho	. •	·)	Balto	Location of Death	1	4c. County of Dea	ith	
	Funeral Director	-7	<sup>5.</sup> <b>218 28 28 78 5 218 78 28 15</b>	6. Sex 7. A	ge (In yrs. last birthday, 71 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	8 <sup>Yea</sup> (933	rthplace (State or Foreign ountry) Md	
land	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 21s marked other than "naturat", or Itams 23s or 28s-1 show any injury or other traumatic event, the Medical Examinat transities inclined at once.		Usual Residence of Decedent  10a. State 10b. County	,	10c. City, Town or L	ocation				10d. Inside City Limits	
ю Магу		ctor		Arundel	Severn					1 ☐ Yes 2 No	
with th		i Dire	10e. Street and Number 1912 Christiana Court 21144						10g. Citizen of What C	ountry?	
<b>)36</b> urs after deetl		Completed by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Mar  3 ☐ Widowed 4 ☒ Divorced	If Ves Give	}No	Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 No	ispanic Origin? (S In, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh SpecifyB1a	ite, etc.	
Maryland 21215-0036		ompieted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  A A Degree 2  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  Youth Counselor					king	16b. Kind of Business/Industry Cedar Knoll Youth Faculties		
rland 2		To Be Co	12th grade 17. Father's Name (First, Middle, John Pyles					ne (First, Middle,	Maiden Sumame)		
Mary 12 sho			19a. Informant's Name/Relations			ing Address (Street a			r, City or Town, State,	Zip Code)	
re, l			Anita Allen- 20a. Method of Disposition		20b. Place of Disp	osition (Name of	T	Date	20c. Location - City o	r Town, State	
Baltimore,			1 Donation 5 Other (	Specify)		emorial P			Laurel, Md		
Bal			21. lign ture Funeral Service	White.	_\\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\	2. Name and Addres		March F/ h Avenue	H West Balto, M	d 21215	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed  within 24 hours alter death.  To the Funstal Director: After this certificate has been signed by the attending physician and  I possible to the funstal Director: After this certificate has been signed by the attending physician and  I possible to the funstal director, page 2 should be detached for use as the burial-transit  I but the function of t		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final								
			disease or condition resulting in death)  a. Due to (or as a consequence of):								
		er	So us fially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b.  Due to (or as a consequence of):  c.  Due to (or as a consequence of):								
), &		Examiner									
38760, icate be exe				d							
P.O. Box 6: het the death certific		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ √√√0 9 □ Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	elivery Day Year	
		۾	Part II. Other significant conditions		but not resulting in the	underlying cause give	en in Part I.	23e. Did to	bacco use contribute es 2 □ No 3 □ F	to the cause of death?  Probably 4 Donknown	
ج ا		Completed	Hyperte	nsive hear	-1- Disc	inse		24a. Was a autop: perfor 1 Yes	sy prior to		
Vita		To Be	25. Was case referred to medica examiner?  1 Yes 2 No	Hospital:	tient 2 ER/Outpatre	ont 3□ DOA Oth	or	ath <i>(Check only or</i> Iome 5 □ Besid	ne) ence 6 ⊡Other (Sp	ecifu)	
on of									8d. Describe how injury occurred		
Divisi		Certification:	3 Suicide 6 Could 4 Homicide deten	nined 200. Place of I	njury - At home, farm, s etc. (Specify)	treet, factory, office		28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,	
Hospita		edicai C	29a. Certifier  (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifier  (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
To the	the the	Mec	29b. Signature and title of certifi-		stateu.	29c. Licens	e number	2	29d. Date signed (Mor	nth, Day, Year)	
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۴	with To Con		1/ whal	A Rounds	IL M		1680		10/27/2	2005	
) °	To so		30. Name and ad ress of person	A Rounds	200 East 35	, Print)	1180 #131 B	EDMURE,	10/27/2 MS 212	15	

		1- State of Maryland / I	Department of Head Certificate of De			2005	35145
Physic	ian	Decedent's Name (First, Middle, Last)			Date of Death Month	Day Year	3. Time of Death
/Medi	ical	Grace E. Arthur  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Lo		tober 2	7, 2005 4c. County of Dea	9:25 P. M
Exami	ner						
Funeral		Augsburg Lutheran Home  5. Social Security Number 6. Sex / 7. Age (In yrs. last bi		f Under 24 Hrs. 8.	Date of Birth	Baltimo:	thplace (State or Foreign
Director		212-03-2659 1□M 2€€F 96	Yrs. Months Days	Hours Min.	(Month, Day, 1971)	909 Mar	vintry) (7 land
P .		Usual Residence of Decedent	m and another				104 Inside City I inside
anyla shov	7	10a. State 10b. County 10c. City, Tow	on or Location				10d. Inside City Limits 1 ☐ Yes 2 → No
the M	ecto	Md Baltimore Locher	n. 10f. Zip Code		10	g. Citizen of What Co	
with e or	ρ		21207				ountry :
If A 12 13-0050 filed within 72 hours after death with the Maryland Hygiene. wher than "naturel", or Items 23e or 28e-1 show ent, the Medical Examinar must be notified at	Funeral Director	6811 Campfield Rd  11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hisp	anic Origin? (Specif	y Yes or No-	.S.A. 14. Race - Ame	
after o		Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	If Yes, specify Cuban,	Mexican, Puerto Ric	can, etc.)	Black, Whit	
ours a	db	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 Ø No	Specify:		Specify: Wh:	Lte
72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during the control of the con	on ing most of working	1	6b. Kind of Business	/Industry
Mithin ne.	mp	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)				
filed v Hygie other t		17. Father's Name (First, Middle, Last)	Sales	8. Mother's Name (F	First. Middle. M	Retail	
ed fa be	To Be	Harry Hastings		Grace Ric		,	
ie, wat ylar	F		o. Mailing Address (Street and				Zip Code)
i, IVICA and 2 s a alth ar n 27 is ner trau		Bruce H. Jones (Son)	233 Kindig Roa	ad Little	estown,	Pennsylva	ania 17340
callinoie, IN rmit. Pages 1 and 2 partment of Health portent: If item 27 y injury or other tra		comete	of Disposition (Name of ary, crematory or other place)	Date	9 2	0c. Location - City or	Town, State
Pages nent of nnt: If it		1 5-Burial 2   Cremation 3   Hemoval from State	aine Park	11-01-	-2005 W	oodlawn ,Ma	aryland
Dalilliole, permit. Pages 1 an Department of Heal Importent: If item any injury or other once.		21. Signature of Funeral Service Licensee	22. Name and Address of 8728 Liberty				Directors I
		23a. Part1. Enter the disease, or complications that caused the death. Do	<del>-</del>	<del></del>			Approximate
2	1	shock, or heart failure. List only one cause on each line.	IMERS				Interval Between Onset and Death
Pnysician /Medical	_	disease or condition resulting in death)  a					
Examiner			ory.				
	je j	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	of):				
cuted or ransii	Examiner	that initiated events					
e exe ian ar urial-t		resulting in death) Last Due to (or as a consequence	of):				
cate be executed physician and the burial-transit	dlcal	d					
	Ψ	IF FEMALE: 230 If you guiteame of programme				1	
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?				23d. Date of de Month	ivery Day Year
the de	yslc	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)				
res that the de igned by the a be detached f	A Ph	Part II. Dther significant conditions contributing to death but not resulting	in the underlying cause given	in Part 1.	23e. Did toba	acco use contribute to	the cause of death?
he law requires t he has been signe sge 2 should be o	d by				1 ☐ Yes	s 2 □ No 3 □ Pi	obably 4 Donknown
w requir	Completed				24a. Was an	24b. Were au	itopsy findings available
The law ate has page 2 s	dmc				autopsy	ed? prior to death?	completion of cause of
	e C	25. Was case referred to medical	2	6. Place of Death (C			22 No
	OB	examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 ER/O	utpatient 3 DOA Other:			nce 6 □Other (Spe	cifv)
SION OF VITA tending Physicien: leath. tor: After this certific the funeral director,	, i	(Month Play Vene)	Time of 28c. Injury at Injury Work?			v injury occurred	,
or Attending Physics of a ster death. Director: After this in by the funeral d	atlo	2 Accident investigation		s 2 🗆 No			
lor Attendate death Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide  3 ☐ Suicide 4 ☐ Homicide	arm, street, factory, office	28f	Location (Street, City or Town,	et and Number or Ri State)	ural Route Number,
rel Di							
To the Hospitel or At within 24 hours after of To the Funerel Direct Completely filled in by	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge in the control of the contro	e, death occurred at the time, nd/or investigation, in my opin	date and place, and ion, death occurred	d due to the cau at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
To the within To the comple	₩	29b. Signature and title of certifier	29c. License n	umber	29	d. Date signed (Mont	h, Day, Year)
		Jasney Hallia	) 3	18121		10/28,	10)-
Y		30 Name and address of person who completed cause of death (Item 23a)	(Type, Part) ARR H	धदाभा	AVE.	BAED M	124208
	tate	31. Date filed (Month, Day, Year) 32. Redistrar's Signature	hante	. ,	, [		
Regis	प्रवा	MOA O T FOOD INCHES	1				

			Plea	se Type or Pr	int in Black In Maryland / Dep					
			For State Registrar	Otate of h	Ce	rtificate of	Death		Reg. No.	35146
B	Physici	an	Decedent's Name (First, Middle Miriam		Arguero			2. Date of Dea Month October	Day Year	3. Time of Death 11:10 a <sup>M</sup>
	/Medio		4a. Facility Name (If not institution				r Location of Death		4c. County of Dea	ath
1		ş	Stella Maris 5. Social Security Number		Age (In vrs. last birthday	Timoni	. UM If Under 24 Hrs.	8 Date of Rid	Baltimo	Thplace (State or Foreign
	Funeral Director		215-42-9898	1 M 2 M F	79 Yrs.	Months Days	Hours Min.	November	v, Year) C	entina
-	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	e Mary	ctor	MD Ba	altimore	Baldu	in				1 ☐ Yes 2X No
	with the a or 28	Dire	10e. Street and Number 13812 Manor G1	en Road		10f. Zip Code 21 01 3	3		10g. Citizen of What C Argentina	ountry?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 3 □ Mar  3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Force: 1	s? ]No	Was Decedent of H If Yes, specify Cuba 1 X Yes 2 No	lispanic Origin? (Span, Mexican, Puerto Specify: Arge	Rican, etc.)		ite, etc.
5-00	72 hou			nt's Education st grade completed)	16a. Dece	edent's Usual Occup a kind of work done DO NOT use retired	ation during most of work	un <b>g</b>	16b. Kind of Business	s/Industry
21215-0036	within iene. then	Completed	Elementary/Secondary (0-12)	College (1-4c		DO NOT use retired ner/Homema			Education/	′Own home
	be filed tal Hyg d other	Be	17. Father's Name (First, Middle,				_	e (First, Middle, Mari	Maiden Sumame)	ncelli
Maryland	2 should be and Mental ris marked or raumatic eve	2	Atilio R.  19a. Informant's Name/Relations			ing Address (Street	Angela  and Number or Rus		or, City or Town, State,	
	and 2 : salth ar n 27 Is		Roberto C. Arg		10010	Manor G				
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra 9000.		20a. Method of Disposition  1  Burial 2 Cremation		20b. Place of Disp cemetery, cre Hillton Ser	matory or other plac	ce)	Date /1/05	20c. Location - City o	20
altin	permit. P. Departme Important any injury		4 □Donation 5 □Other (S 21. Signature of Funeral Service						n Funeral	
8	88 8 8		23a. Part1. Enter the disease, or	s complications that cause		050 York	··		21204	Approximate
68760,	Physician and // Medical Examiner transit the prival-transit	icai Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, it is a larger or injury that initiated events resulting in death) Last	a. META  Due to (or a  b. Due to for a	STATIC CANCES a consequence of conse	CER				Interval Between Onset and Death
.O. Box	uires that the death certificate be signed by the attending physicie Id be detached for use as the bui	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		2 Fetal death 31 at time of death 51	□Ectopic pregnancy	,		23d. Date of de Month	blivery Day Year
ds, P	equires tha sen signed lould be det		Part II. Other significant conditi	ons contributing to death	but not resulting in the t	anderlying cause giv	en in Part I.		obacco use contribute to	robably 4 TUnknown
Il Records,	The law req ate has been page 2 shou	Completed						24a. Was a autop perfor	an 24b. Were a sy prior to death?	utopsy findings available completion of cause of
of Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital:	itient 2 ER/Outpatie	int 3 DOA Oth	26. Place of Dear		ne) Ience 6 <b>∑</b> Other <i>(Spe</i>	noted HOGDIGE
Division of	Jing After fune	Certification: To	27. Manner of Death  1 Natural 5 Pendir 2 Accident investi	28a. Date of Ir ng (Month, I		of 28c. Injur Wor			now injury occurred	HUSPICE
Divi	after d Direct Jin by	ertifi	3 Suicide 6 Could 4 Homicide determ	nined 286. Place of	njury - At home, farm, si etc. <i>(Specify)</i>	treet, factory, office		28f. Location (S City or Tow	Street and Number or F vn. State)	lural Route Number,
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one)	ng Physician: To the be Examiner: On the basis and manner	of examination and/or in	th occurred at the tirnvestigation, in my o	ne, date and place, pinion, death occur	and due to the ored at the time, or	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the To the To the Company of the To the Company of the To the	Ž	29b. Signature and title of certifie			29c. Licens	e number	i	29d. Date signed (Mon	
			30. Name and address of person	who completed cause o	death (Item 23a) (Type	, Print)	15125		10/31	105
	District Land		DR. TARIQ MAH 31. Date filed (Month, Day, Year,		DULANEY VAL	LEY RD.	TIMONIUM	MD 210	93	
`	Sta Regista	_91	NOV 0	1 2005	SAL A A	Jack				
DH	IMH 17 Rev 1/2	001			8					

			Please 1	Type or Print in				•		-		
			For State Registrar	State of Marylar		irtment of F <i>tificate of</i>		ental Hy	giene Reg. No	- Comp	35	147
	Physici	22	1. Decedent's Name (First, Middle, Las					2. Date of De Month	_	y s Year		of Death
	/Medic	al .		ndreone		41. O't. T		October		2005 County of Deat		10 PM
	Examin	er	4a. Facility Name (If not institution, give Oak Crest Care Ce	nter		Parkvill			Ba	altimore		
	Funeral Director		14-20-7100	X 7. Age (In yrs	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month D VOV. 1	rth ay, Year)	927 Mar	y land	e or Foreign
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation					10d. Inside	City Limits
	Mary me-f sh	tor	MD Baltimor	Par	kville						1 □ Y	es 2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avant. It have also be accounted to the confiled at once.	al Director	10e. Street and Number B800 Walther Blvd.	Apt. 2005		10f. Zip Code 21234			10g. Cit	tizen of What Co	untry?	
	ems ?	Funeral	11. Marital Status	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☑ No	J.S. 13. V	Vas Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No Rican, etc.)	0-	14. Race - Ame Black, White		
036	urs afte	by	1 ☐ Never Married 2 🖔 Married 3 ☐ Widowed 4 ☐ Divorced	1	1	□ Yes 2 No				Specify: W	hite	
21215-0036	n 72 ho "natur edical	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Deced	lent's Usual Occup kind of work done OO NOT use retire	oation during most of workind)	ng	16b. K	ind of Business/	ndustry	
212	d withii giene. ar than	Somp	Elementary/Secondary (0-12)	College (1-4or 5+)		person	-,		Depa	artment	Store	
Maryland	uld be file fental Hy rked oth	To Be (	17. Father's Name (First, Middle, Last) Andrew G. Zeiler				18. Mother's Name Mary Lou			Sumame)		
Mary	d 2 shouth and Mand Mand Mand Mand Mand Mand Mand		19a. Informant's Name/Relationship (7 Kathleen M. Younk			-	and Number or Rura gers Way;					
	of Heal	1	20a. Method of Disposition	20b.	Place of Dispos	sition (Name of natory or other pla	D	ate	_	ocation - City or		
i i	Page ment cant: if		1 ☑ Burial 2 ☐ Cremation 3 ☐ • 4 ☐ Donation 3 ☐ Other (Specify				dens 11/2,	/05		onium, M		
Baltimore,	permit Depart Import any in	1 1	21. Signature of Funda Fervior Lichn			. Name and Addre	n Funeral	Home		050 York owson, M		04
	-		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the dea	th. Do not ente	er the mode of dyi	ng, such as cardiac o	r respiratory a	arrest,		Approxim Interval E Onset an	Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Parkinse		Diseu	5 6					
	Examiner			Due to (or as a conse	quence or):							
	sit s	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):							
0,	executed n and ial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a conse	quence of):							<u> </u>
68760	ite be e iysiciar ne buri	_	· ·	d								
39 ×	entifica ding pt se as tl	/Med	IF FEMALE:	23c. If yes, outcome of pregr	ancy					23d. Date of deli		
Box.	The faw requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	Ectopic pregnanc Other <i>(specify)</i>	y 			Month	Day	Year
P.0	nat the d by th letache	Phys	9 Unknown  Part II, Other significant conditions or		outling in the ur	dorhing cauco g	on in Bart I	23a Did	tobacco	use contribute to	the cause o	of death?
ds,	w requires that the s been signed by the should be detach	by	Partit, Other significant conditions of	minibuling to dealin but not re	saling in the a	idenying cause gi	rent in Fatti.		Yes 2		obably 4 (	
cor	s been s been	olete						24a. Was		24b. Were au	lopsy finding	gs available
Vital Records,	sician: The law scertificate has b lirector, page 2 s	Completed						auto perf	ormed? 2 4 No	death?	2 Ho	r cause or
/ita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		0**	26. Place of Death					
	Physi r this c ral dir	: To	1 ☐ Yes 2 ☐ No  27. Manner of Death	1 L Inpatient 2L	ER/Outpatien 28b. Time of	t 3 DOA	4 Nursing Hon	ne 5 Res 28d. Describe			ify)	
ion	Attanding r death. actor: After by the fune.	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury	Wo	rk? Yes 2 □ No			,		
Division of	after des after des Diracto	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At l building, etc. (Spec	nome, farm, stra ify)	eet, factory, office	2	28f. Location City or To	(Street ar	nd Number or Ru e)	ral Route No	umber,
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)	ysician: To the best of my kr iner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the ti restigation, in my	me, date and place, a opinion, death occurre	and due to the	cause(s , date an	and manner as d place, and due	stated. to the cause	Θ(s)
	To tha within . To tha	Mec	29b. Signature and title of certifier			29c. Licens	se number		29d. Da	ite signed (Month	, Day, Year	;)
			I cu mo	não, m	15	05	8646		0	ctuber	31	2005

State Registrar leal ther Bolevard

6. Registrar's Signature

Parksille

MD 21234

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8800

Anna Manias 88 31. Date filed (Month, Day, Year) NOV 0 1 2005

State of Maryland / Department of Health and Mental Hygie Pen 05 35148 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Yeer Month **Physician** William Whitfield Beck Oct. 27 2005 10:40°a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 29 Breaker Court Baltimore Baltimore 8. Date of Birth (Month, Day, Year)

June 27, 1934

9. Birthplece (Stete Country)

Virginia If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days M 2□ F 223-38-8607 71 Director Usual Residence of Decedent deeth with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location in than "natural", or iteme 23a or 28a-f ehow the Medical Examination routing at 1 Yes 2 No MD Baltimore Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 29 Breaker Court 21221 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 11 Marital Status permit. Peges 1 and 2 should be filed within 72 hours after i Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural," or Iter eny injury or other traumatic event, it a Medical Examinat once. 1 X Yes 2 □ No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: White 1 ☐ Yes 2 ☐No Specify: ģ 3 ☐ Widowed 4 1 Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Beth Steel Elementary/Secondary (0-12) College (1-4or 5+) Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lewis Henry Beck Isabel Shumake 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O.Box 838 Philippi WVA 26416 Lewis H. Beck /brother 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition BayviewCrematory 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 11/1/05 Baltimore MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 21221 onn 23a. Part 1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List on the cause on each line. Inter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Cardiovascy **Physician** Lenotic MENIOSC 10 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No should be detached the 9 🗌 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an page 2 autopsy performed? Yes 200 No has certificate 1 ☐ Yes 26. Place of Death (Check only one) director Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Yes 2 No this 28a. Date of Injury (Month, Day Yeer) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury To the Hospitel or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident the within 24 hours after deals To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Trimble HillCT Luther : lle Maryland Militello Jh. MU 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 0 0 5 Certificate of Death Reg. No. t's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 0: 45AM **Physician** - 25- 05 /Medical institution, give street and number) Examiner If Under 1 Year | If Under 24 Hrs. 6. Sex (In\_yrs. last birthday) **Funeral** Hours 1 M 2 F 218-05-Director death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits if item 27 is marked other then "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at Ba Kesville 1 ☐ Yes MNo Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 2120 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after on tof Health and Mental Hygiene. Int: if item 27 is marked other then "natural", or item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0 Be 19b. Mailing Address (Street and Number 19a. Informant's Nam (Relationship (Type Print) Department of Health a Important: if item 27 is any injury or other trains once. Method of Disposition 20c. Location - City or Town, State 2 Cremation 3 Removal from State 5 Other (Specify) 21. Signature of Funeral Service J 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumona weeks /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ending physicien and r use as the burial-transit Division of Vital Records, P.O. Box 68760,inesDue to (or as a consequence of): Physician/Medical ate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetaf death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown ementia 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hyper tension 1 ☐ Yes 30 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification; To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Naturaf 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral Completely filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar 2435

32. Registrar's Signature

2005

Baltimae

vedere Ave

Chow

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chow

31. Date filed (Month, Day, Year)

	State of Maryland / Department of F  State Registrar  State of Maryland / Department of F  Certificate of Registrar	Death Reg. i	No.
Physician /Medical	1. Decedent's Name (First, Middle, Last)  James Allen Butler	2. Date of Death Month October	3. Time of Death 1:05 P M
Examiner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, o  Gilchrist Center  Towson		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 127-32-5997  6. Sex 1 🔀 M 2 🗆 F  7. Age (In yrs. last birthday) Months Days	Hours Min. 8. Date of Birth (Month, Day, Yes	9. Birthplace (State or Foreign Country) 1941 Rhode Island
/ O /	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Maryland Howard Ellicott City  10e. Street and Number 10f. Zip Code		10d. Inside City Limits 1 ☐ Yes 2 XNo  Citizen of What Country?
indeath with the Miles 23a or 28a-f.	700. 51.501 41.0	042	USA
J36 J36 Jis after arriting marging by Fur	11. Marital Status  1 Never Married 2 Married  3 Was Decedent Ever in U.S. Armed Forces?  1 Yes, 2 No 1958  1 Yes, 3 No 1962  1 Yes 2 No 1962		14. Race - American Indian, Black, White, etc.  Specify: White
21215-0036 ed within 72 hours after ygiene. The Madrial Equipment, the Madrial Equipment of the Madrial Equipment of the Madrian	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 4  Building Eng	during most of working d)	o. Kind of Business/Industry uilding Management
faryland 2121 2 should be filed within and Mental Hygiene. Is marked other than raumatic event, the Mary To Be Comp	17. Father's Name (First, Middle, Last)  James Benjamin Butler	18. Mother's Name (First, Middle, Maio Claudia Faison	den Sumame)
re, Maryland 2121 re, Maryland 2121 s 1 and 2 should be filed within Health and Mental Hygiene. Health and Mental Hygiene. To Be Compo	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street	and Number or Rural Route Number, Cit Road Ellicott Cit	y, MD 21042
altimore, Marini, Pages 1 and Spartment of Health programs: If them 27 by injury or other truce.	20a. Method of Disposition  1  Burial 2 XI Cremation 3  Removal from State 4  Donation 5  Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other pla	сө)	c. Location - City or Town, State  1timore, Maryland
Baltimore permit. Pages 1 Department of the Important: If the any injury or of ance.		Society Of Marylan rick Road Baltimore	
Physician /Medical Examiner	Due to (or as a consequence of):	ng, such as cardiac or respiratory arrest,	Approximate Interval Between Onset and Death
68760, cate be executed physicien and it the burial-transit	Sequentially list conflicins if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  c.  Due to (or as a consequence of):		
D. Box 6 be death certiff the attending hed for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 5 □ Other (specify) □ Unknown	у	23d. Date of delivery Month Day Year
ds, P.(	Part II. Other significant conditions contributing to death but not resulting in the underlying cause gr		co use contribute to the cause of death?  2 No 3 Probably 4 Nonknown
II Record The law requires the law requires the law speen speen speed to be should be		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?  No 1 □ Yes 2 X No
E ng eur	27. Manner of Death  28a. Date of Injury  (Month, Day Year)  28b. Time of 28c. Injury  (Month, Day Year)	26. Place of Death Check only one) ther: 4 Nursing Home 5 Residence try at 28d. Describe how in the control of	
Division C To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
Div	29a. Certifier (Check only one)		
To the within 2 To the complete	29b. Signature and title of certifier  29c. Licentifier	29d.	Date signed (Month, Day, Year)
119	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Pendelo R Faulkner MD / Udo I New	west/Bolt	60 MD 21204
State	31. Date filed (Month, Day, Year)  32. degistrar's Signature		

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygieme O O C

Enueral Director  The Medical Exam Der count by Darking and Director  To Monte Director	a. Facility Name (If not institution, give s 810 Wilson Point Social Security Number 6. Sex 13-62-3422 sual Residence of Decedent 0a. State 10b. County MD Baltimo 0e. Street and Number 810 Wilson Poir 1. Marital Status 1 Never Married 3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12th 7. Father's Name (First, Middle, Last)	Road  7. Age (In yrs. last 51  10c. City, Tore  12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent Ever in U.S. Cation	t birthday) Yrs.  4b. Ci  Ess. Month  Yrs.  10f. J.  13. Was Decident's U.  16a. Decedent's U.	on Po: Zip Code 21220 cedent of Hispecify Cuban,			4c. County of De Baltimore Baltimore 4, 1954 Ma	5:45 A     ath   e     inhiplace (State or Fore Country)     Cryland     10d. Inside City Lim     1   Yes 2			
Tringing after death with the Maryland Tringing 23 or 23s	810 Wilson Point  Social Security Number  13-62-3422  Sual Residence of Decedent  Oa. State MD Baltimo  Oe. Street and Number  810 Wilson Point  1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced  (Specify onfy highest grade  Elementary/Secondary (0-12) 12th  7. Father's Name (First, Middle, Last)	Road  7. Age (In yrs. last 51  10c. City, Tore  10c. City, Tore  12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was 2 \( \) No If Yes, Give Year or Dates:	Fown or Location  Wilso  13. Was Der  If Yes  To Person of Control  To Person of Control  Wilso  Wilso  To Person of Control  Wilso  Wilso  To Person of Control  Wilso  To Person of Control  Wilso  Wilso  To Person of Control  Wilso  To Person of Control  Wilso  Wilso  To Person of Control  Wilso  Wi	Sex  der 1 Year Is Days  On Po:  Zip Code 2122  cedent of Hisp pecify Cuban, 3 2 XNo	If Under 24 Hrs. Hours Min.  int  O panic Origin? (Spe, Mexican, Puerto	8. Date of Bird (Month, Da Feb. 13	4c. County of De Baltimore Baltimore 9, 8, 1954 Ma	ath  e inhplace (State or Fore Country)  ryland  10d. Inside City Lim 1			
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Tribute after Death with the Maryland Tratural', or iteme 23a or 28a-t show The control of the c	sual Residence of Decedent  Oa. State  MD  Baltimo  Oe. Street and Number  810 Wilson Poir  1. Marital Status  1 Never Married  3 Widowed 4 Divorced  (Specify only highest grade (Specify only highest grade 12th  7. Father's Name (First, Middle, Last)	at Road  12. Was Decedent Ever in U.S. Armed Forces?  1X Yes, Give Year or Dates:  Cation a completed)	Fown or Location  Wilso  106.  13. Was Decident's U.  (Give kind of	On Positive Code  Zip Code  2122  cedent of History Cuban, code 2 X No	int  O panic Origin? (Spe, Mexican, Puerto	Feb. 13	10g. Citizen of What C	10d. Inside City Lim 1 □ Yes 2苍1 Country?			
ratural, or iteme 23a or 28a-1 show dical Exams her must be notified at eted by Funeral Director	sual Residence of Decedent Oa. State  10b. County  MD  Baltimo Oe. Street and Number  810 Wilson Poir  1. Marital Status  1 Never Married  3 Widowed 4 Divorced  (Specify only highest grade  Elementary/Secondary (0-12)  12th  7. Father's Name (First, Middle, Last)	nt Road  12. Was Decedent Ever in U.S. Armed Forces?  1X X 8 s 2 No If Yes, Give Year or Dates:  cation e completed)	Fown or Location  Wilso  10f. 3  13. Was Der  If Yes, s  1 □ Yes  16a. Decedent's U.  (Give kind of	on Po: Zip Code 21220 cedent of Hisp pecify Cuban, 2 (X)No	O panic Origin? (Spe , Mexican, Puerto		10g. Citizen of What C	10d. Inside City Lim 1 □ Yes 2苍1 Country?			
or more training to course and order mainter marylar at Hydrone.  Jother then "natural", or iteme 23e or 28e-4 ehow went, the Medical Examinar must be notified at twent, the Medical Examinar must be notified at 1.	MD Baltimo  Oe. Street and Number  810 Wilson Poir  1. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Edur (Specify only highest grade  Elementary/Secondary (0-12)  12th  7. Father's Name (First, Middle, Last)	nt Road  12. Was Decedent Ever in U.S. Armed Forces?  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent Ever in U.S. Armed Forces?  14. Was Decedent Ever in U.S. Armed Forces?  15. Armed Forces in U.S. Armed	Wilso  10f. 3  13. Was Decident's U.  (Give kind of	Zip Code 2122  cedent of Hisp pecify Cuban, 22XNo	O panic Origin? (Spe , Mexican, Puerto	ecify Yes or No Rican, etc.)	USA	1 □ Yes 2 🛣			
and Hygiene and Hy	0e. Street and Number  810 Wilson Poir  1. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Edur (Specify only highest grade Elementary/Secondary (0-12)  12th  7. Father's Name (First, Middle, Last)	nt Road  12. Was Decedent Ever in U.S. Armed Forces?  12. Was 2 No If Yes, Give Year or Dates:  cation e completed)	13. Was Der  13. Was Der  14. Yes  15a. Decedent's U.  (Give kind of	Zip Code 2122  cedent of Hisp pecify Cuban, 22XNo	O panic Origin? (Spe , Mexican, Puerto	ecify Yes or No Rican, etc.)	USA	Country?			
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alth and 27 is m at treum er treum	9a. Informant's Name/Relationship (Ty, Karen Blankens		_				ar, City or Town, State, lltimore				
y or oth	0a. Method of Disposition 1 ☐ Burial 2XC Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State 20b. Place Semi	ee of Disposition (A letery, crematory of VV1eWC16	Name of or other place) ematol	ry 10/	31/05	20c. Location - City of Baltimor				
Department Importent eny Injury Once.	21. Signature of Funeral Service License	of Commell	22. Name	and Address	of FacilityCon	nellyF	uneralHo timore M	meofEsse			
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Ion Ion	7. Manner of Death 1 Natural 5 Pending 2 Accident	round,	Bb. Time of <b>unk</b>				now injury occurred	unk			
Medical Certification:	3 Suicide 4 Homicide 6 Could not be determined	10-28-05  28e. Place of Injury - At home building, etc. (Specify)  Found at home	e, farm, street, fact	tory, office		28f. Location (S City or Tow Wilson	Street and Number or F vn, State) 810 W Point, MD	Rural Route Number,			
thin 24 hours thin 24 hours the Funeral mpletely fille	29a. Certifier (Check only one)  1 Certifying Physical Control one)	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death occurre	ed at the time ion, in my opir	, date and place,	and due to the	cause(s) and manner a	is stated.			
Me 29	9b. Signature and title of certifier	4 = 1	. 2	29c. License r OCME	number		29d. Date signed (Mor	nth, Day, Year)			
30	0. Name and address of person who co	alle II II Completed cause of death (Item 23	2(			t Balt	October 28, imore, Mar	_2005 yland 2120			
State 31	11. Date filed (Month, Day, Year)	32. Registrar's Signature	of South								

State of Maryland / Department of Health and Mental Hygiens 35152 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 26, October 2005 Anna Bierer 6:54 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1032 West Seminary Ave. Lutherville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F 075-12-1022 87 Director January 11,1918 Monongahela.PA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show itsm 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore County Lutherville 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 1032 W. Seminary Ave. 21093 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status 1 ☐ Yes 2 ŽŠNo If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: Specify White 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 end 2 should be filed within nent of Heelth and Mental Hygiene. ent: if itsm 27 is marked other then " College, (1-4 or 5+) Elementary/Secondary (0-12) n/a Home Maker Own Home Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Wosilek Julia Biro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs.Donna L. Sullivan (Daughter) 1032 W. Seminary Ave. Lutherville, Maryland 21093 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Department o important: if any injury or injury or 4 □ Donation 5 □ Other (Specify) Evans Funeral Chapel Oct. 28, 2005 Forest Hill, Maryland permit. 21. Signature of Funeral Service License Peaceful Alternatives Funeral&Cremation Ctr.,P.A. 2325 York Road Timonium, Maryland 21093 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immuniate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the attending physicien and d be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 5 Other (specify) P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, page 2 should be ERTENSION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed CHOLESTEROI 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home SK Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospitel or Attending within 24 hours after death.
To the Funersi Director: Afte completely filled in by the funs. Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D46494 MO 2005 30. Name and artess of person who completed cause of death (Item 23a) (Type, Print) NOOR FAIRMOUNT AUE 515 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar NOV 0 1 2005

				For State Registrar	State of Ma	ıryland	/ Depa	rtment of I tificate of	Health and I <i>Death</i>	Mental Hy	/giene	005	35153
				1. Decedent's Name (First, Middle, Las	t)					2. Date of D Month		Van	3. Time of Death
		Physici /Medi		Kenneth Dean B	owman					10/28	/200	)5 Year	7:25 A M
	à.	Examir		4a. Facility Name (If not institution, give	street and number)			4b. City, Town,	or Location of Deat	h	4c.	County of Dea	
				239 Asbury Roa	d			Pasade				ne Ar	undel
~		Funeral Director		214-52-8983	7. Age	(In yrs. las	t birthday) Yrs.	Months Days		8. Date of B (Month, D 06/03	rth ay, Year) 194	9. Bir Co	thplace (State or Foreign puntry) PA
th	Curo	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Lor	ation					10d. Inside City Limits
a	10	with the Maryland a or 28a-f ehow Le rollijed at	ō		2.1								1 Yes 2 No
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, ž		death me 23	Funeral Director	11. Marital Status	12. Was Decedent E	ver in U.S.	13. V	Vas Decedent of	Hispanic Origin? (S	pecify Yes or N	0-	14. Race - Ame	
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K		is 1 and 2 of Health Item 27 I		Lloyd Stern /	Brother								e, MD 2122
ENNETH	Baltimore,	of H if Ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State			sition (Name of atory or other pla		Date	20c. Lo	cation - City or	Town, State
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				30. Name d address of person who	completed cause of de	ath (Item 2	3a) /Tuna	Print)			10	11981	0)
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AEM #05-07086 John

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Maryland / Department of Health and Mental Hygiene	005	251
Certificate of Death	000	JUL

R	aymond	Br	OW <b>RC</b> State Registrar	State of M	laryland / De <i>C</i>	partment of I ertificate of		Mental Hy	/gienze) (	)5 3	5154
	Physicia /Medic	an	Decedent's Name (First, Middle, La:     John Raymond Bre					2. Date of D Month Octobe:	Day	Year	3. Time of Death 1:28 A M
	Examin		4a. Facility Name (If not institution, given 43 A Street # 1		)	4b. City, Town, CLaure1	or Location of Dea	ith		ty of Death Ce Geor	ge's
	Funeral Director		5/9-64-6640	9x 7. A	ge (In yrs. last birthda 57 Yrs.	Months Days			lay, Year)	9. Birthplac Country Mary1	ce (State or Foreign r) and
	Maryland		Usual Residence of Decedent           10a. State         10b. County           MD         Prince	George's	10c. City, Town or			-		10d	I. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with the 13a or 286 at be not	<u></u>	10e. Street and Number 43 A Street #1			10f. Zip Code	20707			f What Country USA	<i>i</i> ?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f show amy injury or other traumatic event. The Marilical Examination multiput and once.	by Fur	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Deceden Armed Forces 1 Tyes 2 Till ff Yes, Give Year or Dates	i? <b>X</b> No	3. Was Decedent of ff Yes, specify Cub		Specify Yes or N into Rican, etc.)	ВІ	ace - American lack, White, etc ify: white	C.
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			30. Name and address of person who	completed cause o	(teach (ftem 23a) (Ty	pe, Print) $111\ P$	enn Stre	et Balt	imore,	Marylan	nd 21201

State Registrar 31. Bate filed (Month, Day, Year)
NOV 0 1 2005

32 Registrar's Signature

_			1 - For State Registrar			Certificate	of Death		1020 0	5 35155	
	Physici /Medic		Decedent's Name (First, Middle, La  C	arol D. Bo	nar			2. Date of Dea Month Oct. 27	Day	3. Time of Death 9:40 P	
0	Examin		4a. Facility Name (If not institution, gir			4b. City, Tow	vn, or Location of Death	1	4c. County		
			Gilchrist Ce  5. Social Security Number  6.		e (In yrs. last birt	hday) If Under 1 Y	Towson  ear   If Under 24 Hrs.	O Date of Birth		ltimore	
	Funeral Director			1□M 2 <b>X</b> ) F			ays Hours Min.	8. Date of Birth (Month, Day) Aug. 3,	1928	9. Birthplace (State or Foreig Country) Mary Tand	ign
ςξ	yland		10a. State 10b. County		10c. City, Towr	or Location				10d. Inside City Limit	its
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1	ath w	rai	24 Acorn Circl	<del></del>			21286			USA	
\0 \cdot \0	filed within 72 hours after death with the Maryland Hygiene. Hygiene, they than "natural", or items 23s or 28s-f show int, the Madical Examiner must be notified.	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces?  1  Yes 2 Y			of Hispanic Origin? (S Cuban, Mexican, Puert No Specify:	pecify Yes or No- o Rican, etc.)	Blac	e - American Indian, ck, White, etc.	
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	be filed ital Hygi id other	BeC	17. Father's Name (First, Middle, Last	1)				ne (First, Middle, M			_
aro/ Marvland	2 should be and Mental is marked o	To B	Leonard I.	Davis, D.D	.S.		E	lanor Cr	owther		
ZZ Z	d 2 should th and Men 7 is marke traumatic	i s	19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Address (St	reet and Number or Ru	ral Route Number	City or Town,	State, Zip Code)	
			Mrs. Cecilia L. H	ymiller/Da		600 Fairv		esternpo			
	8 5 5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [			Disposition (Name o				City or Town, State	
12 mil	permit. Page Department of Important: If sny injury or once.		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		Morerar		1 Park 10/			e, Maryland al Home, Inc.	_
Baltimor	perm Depa Impo sny ii		much	1 Du	l/		ork Road				
73	T., 451	Y	23a. Part1. Enter the disease, or com shock, or heart failure. List only	polications that caused	the death. Do n					Approximate	
	Physician		Immediate Cause (Final disease or condition		Canon					Interval Between Onset and Death	
	/Medical	8	resulting in death)	a	a consequence o					years	
	Examiner	_	Sequentially list conditions,	b							
	ed isit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence o	f):					
	xecut	Examiner	that initiated events resulting in death) Last	cDue to (or as	a consequence o	f):					
68760.	tificate be executed g physician and as the burial-transit		l	d	,						
	tificati ig phy as the	edicai		· ·							
Вох	eath cert attendin for use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		3 □Ectopic pregna	ancy		23d. Date	e of delivery	
	that the death cer ed by the attendir detached for use	by Physician/M	in the past 12 months?  1 Yes 2 No	4☐Pregnant at 9☐ Unknown		5 ☐ Other (specify			Mor	nth Day Year	
9.	that the ed by detack	Phy	9 ☐ Unknowh\ Part II. Other significant conditions	contobuting to death by	ut not resulting in	the underlying source	a green in Dord I	220 Did tob		ibute to the cause of death?	-
ds.	Physician: The law requires that the death certificate be executed tribic certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	d b		somming to doding	it not resexing in	the underlying cause	given in Paiti.	1 □ Ye	.10	3 Probably 4 Unknown	'n
Ö	w requir been si should	Completed						24a. Was ar	1		
e B	The lav	dmo						autopsy perform	ped? d	Vere autopsy findings available rior to completion of cause of leath?	
<u>ta</u>	ician: Th certificate ector, pag	Be C	25. Was case referred to medical				26 Place of Dea	1 Yes 2	4	Yes 2 No	
>	Physici this cer al direc	To B	examiner? 1 ☐ Yes 2.☑ No	Hospital:	nt 2 ER/Out	patient 3 DOA	Other	ome 5 Reside		or (Specify) MAS as To	
0	ding Physician: n. After this certific funeral director,	:uc	27. Manner of Death 1 Statural 5 ☐ Pending	28a. Date of Injur (Month, Day		me of 28c. I	njury at Work?	28d. Describe ho			
<u>S</u>	Attending or death.	catio	2 Accident investigatio			М	1 ☐ Yes 2 ☐ No				
Division of Vital Records. P.O.	or Att	Certification:	4 Homicide determined	28e. Place of Inju- building, etc	iry - At home, far (Specify)	m, street, factory, offi	ice	28f. Location (Str City or Town	eet and Numbe , State)	er or Rural Route Number,	
	S E S		29a. Certifier Check only 2 Medical Exa	nysician: To the best of	if my knowledge,	death occurred at th	e time, date and place,	and due to the ca	use(s) and mar	ner as stated.	
	the H thin 24 the F mplete	Medical		miner: On the basis of and manner sta	ted.						
	To Voit		29b. Signarure and title of certifier	-	WO	the same of the sa	S8303	29		(Month, Day, Year)	
			30. Name and address of person who	completed cause of de	eath (Item 23a) (1						
A -			AMACON CHARLER	S 6601 N	. Charle	-	DENSON MO	750215			
10	Sta		31. Date filed (Month, Day, Year)		r's Signature	1 . 11					
<b>9</b>	Registra		NOV 0 1 2	005	1 15 1	graves.					

		1 - For State Registrar	te of Maryland / Depa	artment of Health and rtificate of Death	Mental Hygier		35156
Physicia		1. Decedent's Name (First, Middle, Last) Betty	Banes		2. Date of Death October 3	Pay 2005 ar	3. Time of Death 5:40 atm
/Medic Examin		4a. Facility Name (If not institution, give street a Pickersgill	und number)	4b. City, Town, or Location of Deat		4c. County of Death Baltimor	
Funeral Director		5. Social Security Number 6. Sex 159–05–1349 1 □ M 2	7. Age (In yrs. last birthday)  BB Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.			ace (State or Foreign
filed within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland typeine.  The right then 'natural', or flems 23a or 28a-f show ent, it is Medical Eraci, nar must be notified at	Director	Usual Residence of Decedent  10a. State 10b. County  MD Baltin  10e. Street and Number	10c. City, Town or Lo		100	1(Citizen of What County	od. Inside City Limits  1 Yes 2 XNo
death with ns 23a or must be c	Funeral Dir	615 Chestnut Avenue	is Decedent Ever in U.S. 13.	21204 Was Decedent of Hispanic Origin? (S	Specify Yes or No-	.S.A. 14. Race - America	an Indian,
ours after or ral', or Iter	þ	1 Never Married 2 Married 1 Hr	]Yes 2 ☑ No	If Yes, specify Cuban, Mexican, Puer 1 Pes 2 No Specify:	to Hican, etc.)	Black, White, в	
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If liem 27 is marked other than "natural", any injury or other traumatic event, it a Medical Exagnes.	Completed	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12)  Co	(Give life.	dent's Usual Occupation kind of work done during most of wo DO NOT use retired) EMAKET	rking	. Kind of Business/Ind Dwn Home	ustry
2 should be filed and Mental Hyg is marked other sumatic event,	To Be C	17. Father's Name (First, Middle, Last) Frank Scarboro	ough	18. Mother's Nai	me ( <i>First, Middl</i> e, <i>M</i> aid NCE	en Sumame) Parke	r
1 and 2 sho Health and P em 27 is me		19a. Informant's Name/Relationship (Type, Pri John W. Banes-son	1207	ng Address (Street and Number or R 7 Stevenson La.,	Towson, MD	21286	
Pages 1 ment of He ant: If iten ury or oth		20a. Method of Disposition  1 □ Burial 2 ☒ Cremation 3 □ Remova  4 □ Donation 5 □ Other (Specify)	Hilltop Ser			Location - City or To	
permit. Departr Imports any inju		21. Signature of Funeral Service Lics see 山岩		1050 York Rd., To		Funeral H 21204	
Physician /Medical		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause immediate Cause (Final disease or condition resulting in death)	s that caused the death. Do not ent se on each line.  Com  Due to (or as a consequence of):	Heart far Heart far For the Stern	c or respiratory arrest,	4	Approximate Interval Between Onset and Death
cate be executed EXPROSICION OF THE PURISH O	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Severe (6. 20 as a consequence of):	Jevter Sten	osis		gen
w requires that the death certific been signed by the attending p should be detached for use as	Physician/Med	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year
quires that t in signed by uld be deta	ed by Ph	Part II. Other significant conditions contributions of Structure (	ng to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	co use contribute to th	e cause of death? ably 4 Unknown
ician: The law recentificate has bee	Completed by		<u>'</u>		24a. Was an autopsy performed 1 Yes 2	prior to con death?	osy findings available inpletion of cause of
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detected for use as the burial-transit	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospita  27. Manner of Death 1 Natural 5 Pending investigation	II: 1 ☐ Inpatient 2 ☐ ER/Outpatient I. Date of Injury (Month, Day Year)  28b. Time of Injury	nt 3 DOA Other: 4 Thursing I	ath (Check only one)  Home 5 The Residence 28d. Describe how in		)
lal or Atten s after dea al Director ad in by the	Certification:	a C Suiside 6 C Could not be	Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	and Number or Rura ate)	Route Number,
the Hospil nin 24 hour the Funeri ppletely filk	edical	(Check only 2 Medicel Examiner: O		h occurred at the time, date and place investigation, in my opinion, death occurred.	urred at the time, date		the cause(s)
To with	Σ	29b. Signature and title of certifier	Kely mo	125205			
Sta	ato	30. Name and address of person who completed a series of person wh	ed cause of death (Item 23a) (Type,	Vit-Claurles St. 1	Salto. 11	nd 2120	££
Regist		10 1 1 500		.*			

			1 - State State Registrer	e of Marylar		artment of H rtificate of L			ene 005	35157
	Physici /Medic		Decedent's Name (First, Middle, Last)     MARG	ARET 0.	. вое	RI		2. Date of Death Month OCTOBER	Day Year 28,2005	3. Time of Death 5:13 A. M
1	Examin	er	4a. Facility Name (If not institution, give street and 6814 BARNETT ROAD	l number)		TC	WSON		4c. County of Dea	TIMORE
	Funeral Director		5. Social Security Number 216-30-9848 1 □ M 3€	7. Age (In yrs. 71	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, 07-29-19	9. Bi 034 N	rthplace (State or Foreign JARYLAND
	Aaryland f ehow	or	Usual Residence of Decedent  10a. State 10b. County  MD . BALTIMORE	10c. Cit	ty, Town or Lo		WSON			10d. Inside City Limits 1 ☐ Yes 2 1 No
	ier death with the Maryland Iteme 23a or 28a-f ehow Der must be notified at	Director	10e. Street and Number 6814 BARNETT ROAD			10f. Zip Code 212		10	g. Citizen of What C	•
036	hours after death tureit, or iteme 23	by Funeral	11. Marital Status  1 Never Married	Decedent Ever in U d Forces? (es & No i, Give X or Dates:	1	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	erican Indian,
21215-003	be filed within 72 ho tal Hygiene. d other than "natur event, ine Medical	Completed	12 YEARS	red) ge (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired ALES REP	uring most of work RESENTAT	IVE	6b. Kind of Business	s/Industry
Maryland	should be file ind Mental Hy marked oth umatic event	To Be (	17. Father's Name (First, Middle, Last) PETER JAMES 0 C	ONNOR			18. Mother's Name	e (First, Middle, Ma BETH VE		IcGOVERN
_	Ta ta		19a. Informant's Name/Relationship ( <i>Type, Print</i> ) LOUIS P. BOERI, JR. (	SON)		•			City or Town, State, ARYLAND, 2	,
imore,	. Pages 1 and the most perion of Healt tant: if Item 2 jury or other		20a. Method of Disposition  1 □ Burial 2 Cremation 3 □ Removal fi 4 □ Donation 5 □ Other (Specify)		LLTOP S	sition (Name of natory or other place SERVICE C	ORP 10-31		OC. Location - City o	r Town, State YLAND, 21204
Balti	permit. Pag Department Important: eny injury o		21. Signature of Funeral Service Licensee	(R.G.RU	TH) RI	JCK TOWSO	N FUNERAL		IOMZOM	,MD.21204
e e	Physician /Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	at caused the deat on each line.  A Cu fe to (or as a consequence of to (or	quence of):	or the mode of dying	s, such as cardiac	nfur nseul	ction	Approximate Interval Between Onset and Death Work VS
,09/8	icate be executed physician and s the burial-transit	dical	that initiated events resulting in death) Last C. Due	Due to (or as a consequence of):						
O. Box 6	The law requires that the death certific ste has been signed by the ettending p page 2 should be detached for use as	Physician/Me	in the past 12 months?	, outcome of pregna ive birth 2 ☐ Feta regnant at time of d inknown	aldeath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
ds, p	uires that the de n signed by the e id be detached f	d by Pr	Part II. Other significant conditions contributing	to death but not res	1 .	nderlying cause give	in in Part 1.	23e. Did toba		to the cause of death?
al Records,		Completed by				0		24a. Was an autopsy performe 1 Yes 2	ed? death?	utopsy findings available completion of cause of s 2 \( \square\) No
t Vital	nysiciar iis certif directo	To Be	25. Was case referred to medical examiner?  1 \( \text{Yes} \) 2 \( \text{No} \)  Hospital:	I 🗌 Inpatient 2 🗍	ER/Outpatien	t 3 DOA Othe		h <i>(Check only one)</i> ime 5 Residen	) ice 6 ☐Other (Spe	9cify)
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	ate of Injury Month, Day Year)	28b. Time of Injury	M 1 🗆 Y	? ′es 2 □ No	28d. Describe how 28f. Location (Stre	eet and Number or F	lural Route Number,
ă	To the Hospital or Ati within 24 hours after d To the Funeral Direct completely filled in by i		29a. Certifier 1 Certifying Physicien: To	uilding, etc. (Specif	fy)  owledge death	occurred at the tim	e, date and place,	City or Town,	use(s) and manner a	s stated.
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Exeminer: On the	ne basis of examina manner stated.	ation and/or inv	vestigation, in my op	inion, death occur	red at the time, dat	e and place, and du	e to the cause(s)
)	F \$ F 0		30. Name and address of person who completed	Myno,	S M	D D 19	589		10-28	
1	Sta Registr		EVANGELOS C, L. 31. Date filed (Month, Day, Year) 3	2. Registrar's Signa	MP	7801 Yo	RKRd	Tonso	N, MO	21204
	ricgisti	ear	NOV 0 1 2001	A CONTRACT	20 M				<del></del>	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend, item, 5, per fft, 849, 11-8-05 vt.

			1 - State Registrar	State of Maryland		rtment of tificate of			Reg. No.	005	35158
	Physici /Medic	63	1. Decedent's Name (First, Middle, Last)  Robert	Balders	ton	Sr.		2. Date of De Month	Day		3. Time of Death 2:28 P M
	Examin	er	4a. Facility Name (If not institution, give substitution of the su			_	or Location of Dea $1\mathtt{timore}$		4c.	N/A	th
	Funeral Director		5. Social Security 381er 6. Sex		st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr	s. 8. Date of Bir	<sup>th</sup> 1 <sup>7</sup> 93	9. Bin Mai	hplace (State or Foreign
	Maryland	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland N/A		Town or Loc imore	ation					10d. Inside City Limits  XXYes 2 □ No
	h with the	ai Direc	10e. Street and Number 3331 Chestnut Aven:	ue		10f. Zip Code 212	11		10g. Citi	zen of What Co USA	untry?
036	perrait. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than *natural; or items 23a or 28a-f show any njury or other traumatic event, it a Medical Exaction found be rediffed at ADE.	by Funeral Director	11. Marital Status  1 Never Married XXMarried 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2XXNo If Yes, Give Year or Dates:	If	/as Decedent of Yes, specify Cut	Hispanic Origin? (! oan, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)		14. Race - Ame Black, Whit Specify Whit	e, etc.
21215-0036	within 72 ho ane. than *natur te Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give k life. D	ent's Usual Occu ind of work done ONOT use retire chine Op	during most of wo ad)	prking		nd of Business	Ondustry  Dye Company
land 2	id be filed ental Hygie ked other ic event, II	To Be Co	Unknown 17. Father's Name (First, Middle, Last) Charles Franklin	Balderston	nac	nine op		me (First, Middle,			bye company
Maryland	nd 2 shou alth and M 27 is mar rr traumat	-	19a. Informant's Name/Relationship (Ty, Tammy Cousins	Daughter			tand Number or A				Zip Code) and 21211
Baltimore,	Pages 1 annount of Mesent: If item		20a. Method of Disposition  1	emoval from State	netery, crem	ntion (Name of atory or other pla Park Cen	netery 11	Date /03/05		dlawn,	Town, State Maryland
Balti	permit. Departe Importe any nji		21. Signature of Funeral Service License	Henss	B: 30	Name and Addr urgee-He 531 Fall	ess of Facility enss-Seit s Road,	z Funera Baltimor	1 Ho e, M	me, Inc aryland	. 21211
185	Physician		23a. Part1. Eyrler the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition			r the mode of dy		c or respiratory a	rrest,		Approximate Interval Between Onset and Death 1
8760, <	/Medical Examiner  bhysician end sthe burial-transit	dicai Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	nce of): nce of):						13 months
.O. Box 6	death certiff e attending id for use as	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3 🔲	Ectopic pregnand Other (specify) _	y		ú	23d. Date ot del Month	ivery Day Year
۵.	quires thet in signed b uld be deta	by	Part II. Other significant conditions con	tributing to death but not resulti	ing in the un	derlying cause gi	ven in Part I.		obacco u /es 2[		the cause of death?
Vital Records,	eicien: The law requires thet the certificete has been signed by th irector, page 2 should be detache	Completed						24a. Was autop perfo 1  Yes		24b. Were au prior to death?	topsy findings available completion of cause of
Ž	Physicien: rthis certific ral director,	To Be	25. Was case referred to medical examiner?  1 Yes 25 No	ospital: 1 SInpatient 2 ☐ EF	R/Outpatient	3□ DOA Ot	har	ath Check only o		Other (Spec	rife)
ion of	ling After fune	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		8b. Time of Injury	28c. Inju		28d. Describe I			,
Division	i 및 if e	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	et, lactory, office		28f. Location (S City or Tox	Street and vn, State,	d Number or Ru )	iral Route Number,
	To the Hospitei within 24 hours a To the Funerel I completely filled	edicai	29a. Certifier (Check only one) 12 Certifying Physical Continue (Check only one)	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death n and/or inve	occurred at the testigation, in my	me, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
<b>.</b>	To th To th comp	Me	29b. Signature and title of certifier	1		29c. Licen				e signed (Monti	
,	\0		30. Name and address of person who co	mpleted cause of death (Item 2	(3a) (Type, P	rint)	24389		िट्येर		7,2005 Itimore MD
	Ψ		Latrina C.	Lemon, M.D	. (	nino 1	Memoria	1 HOD	pito	J Ba	Itimare MD
の一次	Sta Registr	_	31. Date filed (Month, Day, Year) NOV 0 1 20	32. Pagistrar's Signatur	A So	ache					

State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 24, 2005 Ella Mae Beyer October 6:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Montgomery Bethesda Carriage Hill Bethesda If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🔀 F 90 Director 558-07-2003 Aug. 16, 1915 Alabama Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a. State r than "natural", or Iteme 23s or 28s-f show the Medical Examiner must be indiffed at 1 ☑ Yes 2 ☐ No D.C. Washington Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2122 California Street, N.W. 20008 United States death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☑ Divorced 16b. Kind of Business/Industry 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) United States other than Elementary/Secondary (0-12) College (1-4or 5+) Overseas Embassy Staff Department of State permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 1e marked othen yinjury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alonzo Moody Mary E. Dorough 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 604 4th Avenue East, Kalispell, Montana 59901 Cynthia J. Chalais/Niece 20b. Place of Disposition (Name of commetery, crematory or other place)
Montgomery
Crematorium, Inc. October 27, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 2005 Bethesda, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Robert A. Pum Bethesda-Chevy Chase, Inc. 755 Bethesda, Maryland 20814-3501 Pumphrey Funeral Home/ 7557 Wisconsin Avenue 21. Signature of Funeral Service Licensee BBay M01356 arul 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failule. List only one cause on each line Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition **Physician** Arrhythmia resulting in death) /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to himselfate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner death certificate be executed burial-transit Cardiovascular Disease and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Congestive Heart Failure as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? jo Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑No the th detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by should be Pneumonia, Aspiration, Right Facial Paralysis Secondary 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? to Metastatic Squamous Cell Cancer, Dysphagia, 24a. Was an page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No Atrial Fibrillation or Attending Physician: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 DNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funerel Director: / completely filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tipe of certifies D35579 October 24, 2005 30. Name and address of person who appleted cause of death (Item 23a) (Type, Print) Susan J. Miller, M.D., 6844 Tulip Hill Terrace, Bethesda, Maryland 32. Registrar's Signature 31. Date filed (Month\_Day, Year) State Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O.

Division of Vital Records,

1.	1	1 - For State Registrar	State of Maryland /	Departme Certifica	ent of Heate of D	ealth and I Death		giene 0	105	3516	0
Margaret Louise Baker  Filterial		1. Decedent's Name (First, Middle, Last)					2. Date of De	ath	Vaar	3. Time of Deat	h
Security of Death North Control Country of Death North Country of De		Margaret Louise	Baker				October	r 3T', 2	2005"	1:35 A	М
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The property of the property o	s after de	1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give				pecify Yes or No o Rican, etc.)	В	Black, White,	etc.	
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Sequentially list conditions   23a Part. Eines the disease or complications that caused the death   10 Part   10 P	al Hy d other	17. Father's Name (First, Middle, Last)			1.00			Maiden Sum	name)		
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Pilysician Medical Examiner	artme ortani injury				and Addres	s of FacilityP 01-	ort A 1		*		
Pilysician Medical Examiner	Dep imp	1 Cauct	In d	Rockvi	ille,	Inc. 300 Maryland	Westo-M	2ntgome	ery Av	enue	=/
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The dical Examiner   Part	Physician	Immediate Cause (Final		ac Arres	e t					Onset and Death	
Sequentials, list conditions,	/Medical				, .						
The state of the s		Sequentially list conditions, b.			ailure						
Section of the standard of t	sit sit	ri any, reading to immediate cause. Enter Underlying		,		<b>.</b> •					
Hypertension   Hype	and il-tran	that initiated events C.			lniarc	tion					_
FEMALE:   23b. Was deceded pregnant in the past 12 months?   1   Yes   2X No   9   Unknown   1   Live birth   2   Fetal death   3   Ectopic pregnancy   1   Live birth   2   State of death   1   Live birth   2   Fetal death   3   Ectopic pregnancy   Month   Day   1   Yes   2X No   9   Unknown   1   Live birth   2   Fetal death   3   Ectopic pregnancy   Month   Day   Month   Day   1   Yes   2X No   9   Unknown   1   Live birth   2   Fetal death   3   Ectopic pregnancy   Month   Day   Mon	sician buria		Hypertension	n							
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25. Was case referred to medical examiner?  1	n cert	IF FEMALE: 23b. Was decedent pregnant 23		ath 3∏Estonia	o pragnancy					ery	
25. Was case referred to medical examiner?  1	ed for	in the past 12 months?	4☐Pregnant at time of death						Month	Day Year	
25. Was case referred to medical examiner?  1	at the	9 Unknown		- 1- 16 1 - 1 - 1		. i. D. di	OZ - Did A				
25. Was case referred to medical examiner?  1	en signer ould be d		nouting to death but not resulting	g in the underlyin	g cause give	n in Part I.					
25. Was case referred to medical examiner?  1	law respectively 2 sh						autor	SV	b. Were auto	psy findings availampletion of cause	able of
29a. Certifier  (Check only one)  29a. Certifier  (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Ye	The page							rmea /	death?	2 <b>/</b> € No	
29a. Certifier  (Check only one)  29a. Certifier  (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Ye	cician:	25. Was case referred to medical examiner?	enital:		Otho		ath (Check only o	one)			
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	Hospital 24 hours 24 hours 24 hours 31 filled 16ly filled	29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Examina	er: On the basis of examination	dge, death occurr and/or investigat	red at the timition, in my op	e, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) and date and plac	manner as s	tated. o the cause(s)	
	o the or	29b. Signature and title of certifier	A		29c. License	number		29d. Date sig	ned (Month,	Day, Year)	
	F 5 F ŏ	1 A Mad	Lasul		D5505	4	0	)ctober	31.	2005	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		30. Name and address of person who con	pleted cause of death (Item 23a	a) (Type, Print)	2000	•			,		
Attan Kasid M.D., 17519 Redland Road, Rockville, Maryland 20855-1233			7519 Redland R	Road, Ro	ckvi11	e, Mary	land 208	55 <b>–</b> 123.	3		
State Registrar  31. Date filed (Month, Day, Year)  NOV 0 1 2005  32 Registrar's Signature			32 Registrar's Signature	Genele	9						

		1	For State	State of Maryland	l / Dep <i>Ce</i>	artment of H <i>rtificate of L</i>	ealth and N D <i>eath</i>		ie 2 0 0 5	35161
			Registrar  1. Decedent's Name (First, Middle, Las.	)				2. Date of Deat	th	3. Time of Death
	Physicia		Dorothy Bittin	Cullinher				Month October	Day Year 25, 2005	9:47 PM <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	100000	4c. County of De	
	LXamii		Laurel Regional	Hospital		Laurel			Prince G	eorge's
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. la	st birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	Year) 9. Bi	rthplace (State or Foreign Country)
	Director		579-12-7119	□M 2√2 F 85	Yrs.	Months Bayo			1920 Wash	
	pu *	-	Usual Residence of Decedent  10a, State 10b, County	10c. City	Town or L	ocation				10d. Inside City Limits
	sho	5	, , , , , , , , , , , , , , , , , , , ,							1 ☐ Yes 2 ☐ No
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	with with	Funeral Director	4933 Harford Aver	1116			0705		USA	
	leath ns 23	era	11. Marital Status	12. Was Decedent Ever in U.S	13.	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-		nerican Indian,
0	riter	필	1 ☐ Never Married 2 🛣 Married	Armed Forces? 1 ☐ Yes 2 ☑ No				Hican, etc.)	Black, Wh	
2-002p	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exam har must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give 12 Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify: W	
ך מ	72 ho natur	Completed	15. Decedent's Ed (Specify only highest gra-	ucation de completed)	(Give	edent's Usual Occupa kind of work done	furing most of work	ring	16b. Kind of Busines	s/industry
7	ithin e. 	du.	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired	)			
V	ygier ygier her th	S	12	0	home	maker	18 Mother's Nam	a (First Middle	OWN hon Maiden Sumame)	ne
ryiand	be fill	Be	17. Father's Name (First, Middle, Last)	detina				izabeth		
7	ould I Mer nark	2	Howard Righter H		19h Mail	ing Address (Street			r, City or Town, State	Zip Code)
g Z	12 st h and 7 is n traun	i j				3 Harford				0705
	1 and Healt em 2; ther 1		Carolyn Madison/c	20b. PI	ace of Disp	osition (Name of		Date	20c. Location - City of	
Baitimore,	Pages nent of ant: if it ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☑ Donation 5 ☐ Other (Specify	Hemoval from State	metery, cre	ematory`or other plac	Θ)			
Bail	permit, Pages 1 and Department of Heali Important: if item 2 any injury or other once.		21. Signature of Funeral Service Licen Anthony D	Pleasant		2. Name and Addres State Ana Baltimore	tomy Boai	rd 655 W	. Baltimor	e Street
			23a. Part1. Enter the disease, or compshock, or heart failure. List only	dications that caused the death					est,	Approximate Interval Between
-	Physician		Immediate Cause (Final		bstru	ctive pul	monary d	isease		Onset and Death over 5 yrs
	/Medical		disease or condition resulting in death)	aDue to (or as a consequ		July Far				
	Examiner		Conventially list conditions	h						
	D ==	ner	Sequentially list conditions, if any, leading to immediate sales. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of):					
	acute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequ	anno of):					
ŠĊ,	icate be executed physician and s the burial-transit		1000 king in doday, and	Due to (or as a consequ	once or).					
68760,	cate t	edicai		d						
_	ding l		IF FEMALE:	23c. If yes, outcome of pregna	ncy				23d. Date of d	lelivery
Box	death certifi e attending ed for use as	cian/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	□Ectopic pregnancy □ Other (specify)			Month	Day Year
o.	0 0 0	Physici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown						
₽.	res that the de signed by the a be detached t	y Ph	Part II. Other significant conditions of	ontributing to death but not resu	ılting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
g	uires sign lid be	d by	congestive	heart failure,				1 🗆 Y	es 2 No 3	Probably 4 Onknown
00	The law requires that lhe ate has been signed by th bage 2 should be detache	Completed	coronary artery	lisease, chroni	c atr	ial fibri	11ation	24a. Was	an 24b. Were	autopsy findings available
Re	he lav e has age 2	m C	coronary arcery	inscase, emioni				autop perfor 1 Tyes	med? death	
g	ician: Th certificate rector, pag	Ö	25. Was case referred to medical				26. Place of Dea	ith (Check only or	1	
>	ysicia s cer direct	0.0	examiner? 1 □ Yes 2 ☑ Mo	Hospital: 1 Inpatient 2	ER/Outpati	ent 3 DOA Oth	er: 4 🗆 Nursing H	ome 5 Resid	ence 6 Other (S)	pecify)
0	Attending Physician: r death. ector: After this certified	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time Injury		y at k?	28d. Describe h	ow injury occurred	
<u>o</u>	ath. r: All	atic	1 Accident 5 Pending investigation	1			Yes 2 □ No			
Division of Vital Records,	after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	me, farm, s	street, factory, office		28f. Location (5 City or Tow	Street and Number or m, State)	Rural Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example	ysician: To the best of my kno niner: On the basis of examinal and manner stated.	wledge, deation and/or	ath occurred at the tin investigation, in my o	me, date and place pinion, death occu	, and due to the dirred at the time, d	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	ro the vithin or the comple	Me	29b. Signature and title of certifier	A		29c. Licens	e number		29d. Date signed (Mo	nth, Day, Year)
)	F 5 F 0		•	700-er	M		24721		October 2	26, 2005
			30. Name and address of person who	or Ale Do	idi	Print)	Jaure	l, m	1 20	708
	Sta Regist	ate rar	31. Days filed (Month, Day, Year)  NOV 0 1 20	32 Registrar's Signa	ture	BAR B				
			1101 0	12 mar 12 m	-					

,	State of Maryland / Department of Health and M	lental Hygienen ∩ 5	3516
ite gistrar	Certificate of Death	Reg. No.	0010
dent's Name (First, Middle, Last)		2. Date of Death	3. Time of De

Physician	
/Medical	
Examiner	

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itama 23s or 28s-f show any ir jury or other traumatic event, the Madical Ezaminetr, unit be notified at QDGS.

CARPENTER, POPLIS

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

_1	For State Registrar	State of M	iai yiai ic	Ce	ertificat	e of D	eath		Re	g. No.	05	35164
ın	<ol> <li>Decedent's Name (First, Middle, Last</li> <li>Doris Claire Ca</li> </ol>							M	ate of Death onth	Day	Year 2005	3. Time of Dea
	4a. Facility Name (If not institution, give	street and number,	)		-	Town, or L Balti	ocation of Deal	th		4c. Co	ounty of Deat	h
1	5. Social Security Number 6. S 2.57-34-5695		ge (In yrs. Ia 85	ast birthda Yrs.	y) If Under Months	1 Year Days	If Under 24 Hrs Hours Min	. (A	ate of Birth fonth, Day,		Co	hplace (State or For ountry) Corgia
	Usual Residence of Decedent  10a. State 10b. County		10c. City,	, Town or	Location							10d. Inside City Li
ctor	MD Carrol:	L	Wood	dbin	e							1 □ Yes 2 🔀
Funeral Director	10e. Street and Number 5611 Manor Dr.				10f. Zip	797				-	on of What Co	
þ	11. Marital Status  1 Never Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	? ] No	3. 13		cify Cuban	panic Origin? ( , Mexican, Puer Specify:				Black, White pecify: W]	
Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or	5+)	(Gi	cedent's Usua ve kind of wo b. DO NOT u	ik done du	ion uring most of wo	orking			of Business/	ŕ
Con		4		Tea	cher			·F1				chools
Be	17. Father's Name (First, Middle, Last)						18. Mother's Na			aiden Si	umame)	
ဥ	Floyd E. Koont:			19h Ma	ailina Address		nd Number or R			City or	Town, State	Zip Code)
	Henry Carpente:		nd)				or. Woo					-,/
100	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	20b. Pl.	emetery, c	position (Nai rematory or o	ther place		Date 3 / 2 (			ation - City or lawn,	
İ	21. Signature of Funeral Service Licer		m	11	22. Name ar	nd Address	of Facility				•	Cremator d, MD 2
	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each	ed the death line.	. Do not e	anter the mod	de of dying	, such as cardia	ac or res	oiratory arre	st,		Approximate Interval Between Onset and Deat
edical Examiner	Samentially list conditions if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	is a consequise a	relial Jence of):	infa	retio	in					1 mont
Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊡ No 9 □ Unknown	23c. If yes, outcom  1 Live birth  4 Pregnant  9 Unknown	2 - Fetaf	death	3 □Ectopic p 5 □ Other ( <i>s</i> į					23	ld. Date of de Month	livery Day Year
ρ	Part If. Other significant conditions of			ulting in the	e underlying (	cause give	n in Part I.					o the cause of death robably 4 Unkr
Completed	Stroke								24a. Was ar autops perform	ned?		utopsy findings avai completion of cause s 212 No
Be	25. Was case referred to medical examiner?						26. Place of De	eath (Ch	eck only on	9)		
2	1 ☐ Yes 2 ☑ No  27. Manner of Death 1 ☑ Natural 5 ☐ Pending	Hospitaf: 1 Inpa  28a. Date of In (Month, D	njury	ER/Outpa 28b. Time Injur	e of	28c. Injury Work	at ?		5 Reside		Other (Spe	ocity)
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Medical C		nysician: To the bes miner: On the basis and manner	of examinat									
Me	29b. Signature and title of certifier	-			29	c. License	number		25	d. Date	signed (Mont	th, Day, Year)
	> Pin w.c		Surgeo			_	1129				er 31,	
	30. Name and address of person who Peter W. Cho 31. Date filed (Month, Day, Year)	Sinai Ho	f death (Item	1 23a) (Ty	Backhim	wre	, Baltin	we	Many	land	1 212	15
ate rar	31. Date filed (Month, Day, Year)	32°Regis	strar's Signa	Tyre A	pre							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie of 05 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 25, **Physician** Emma Courlander October 2005 5:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Potomac Manor Care-Potomac Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Days Hours 1 □ M 2 🛛 F 075-14-9444 Yrs. 86 February 23, 1919 New York Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5512 Brite Drive 20817 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No þ Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home

17. Father's Name (First, Middle, Last) Joseph Meltzer

21. Signalore et Funeral Service Licensee

**Funeral** 

**Director** 

rai', or items 23a or 28a-f show Examiner must be notified at

"natural",

al Hygiene.

Be

Examiner

Physician/Medical

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Completed

Be

Certification: To

Medicai

permit. Pagas 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any liquy or other traumatic event ones.

**Physician** 

/Medical

physician and as the burial-transit

957

the

certificate

After this

Director:

within 24 hours a

Hospital or Attending Physician:

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examiner

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

Ray Goodman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19a. Informant's Name/Relationship (Type, Print) Michael Courlander / Son

9 Joshua Tree Court, Gaithersburg, Maryland 20878

18. Mother's Name (First, Middle, Maiden Surname)

20a. Method of Disposition 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 28, Norbeck Memorial Park 2005

Olney, Maryland

M00803 23a. Part 1. Enter the disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

Immediate Cause (Final disease or condition resulting in death)

Cerebrovascular Accident

Approximate Interval Between Onset and Death Days

Due to (or as a consequence of): Parkinson's Disease

Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Lumbosacral Disc Disease

Due to (or as a consequence of):

Due to (or as a consequence of):

Years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2X No

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4□Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No. 3 ☐ Probably 4 X Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 🛣 No 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No

25. Was case referred to medical examiner?

Hospital: 1 | Inpatient

Other: 2 ER/Outpatient 3 DOA

1 TYes 26. Place of Death (Check only one) 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

1 ☐ Yes 2 🗓 No 27. Manner of Death

1 XNatural

2 Accident

5 Pending

28a. Date of Injury (Month, Day Year) investigation

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

D35792

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title 9

1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

October 26, 2005

S.G. Rao, M.D 50 West Edmonston Drive, Rockville, Maryland 31. Date filed (Month, Day, Year)

State Registrar

2005 NOV 0

32. Registrar's Signature

		1	For State Registrar	State of M	Marylan	d / Depa <i>Cei</i>	artmer rtificat	nt of He e of D	alth and l	Mental Hyg	iene og. No.	005	35164	
Dhya	ğ jo		1. Decedent's Name (First, Middle, Last							2. Date of Deat Month	Day	Year	3. Time of Death	4
Phys ⊚ /Me	edica	al	JENNIE	-11	nel	CA	PLAN	Town or I	ocation of Deat	OCTOBER		2005 County of Deal	5:21 A A	
Exa	mine	r	ta. Facility Name (If not institution, give HOSPICE OF BALTI			Г	40. Oily		ISON			-	TIMORE	
Fune: Direct			5. Social Security Number 6. Se			last birthday)	If Unde Months	r 1 Year	If Under 24 Hrs Hours Min.		1 <sup>°</sup> 910	9. Bin Co	thplace (State or Foreig buntry) MD	n
pug *	61		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	ocation						10d. fnside City Limit	s
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th the or 28a		Funeral Director	10e. Street and Number				10f. Zi	p Code		1	0g. Citiz	zen of What Co		
ath wi		ral	3912 FORDS LANE			2 45		d	21215	Sanathi Van or No	1	I4. Race - Ame	USA	
ter de		nue	11. Marital Status 1   ↑ Never Married 2 Married	12. Was Decede Armed Force 1 Tes 2	int Ever in U. \$? <b>X</b> ]No					Specify Yes or No- to Rican, etc.)		Bfack, Whit	te, etc.	
urs af		۵	3 Widowed 4 Divorced	ff Yes, Give Year or Date			1 🗆 Yes	2 <b>X</b> No	Specify:			Specify:	WHITE	
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mit. Pages partment of f portant: If it			1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		ate I	TH JAC				31/2005	FI	NKSBUR	G, MD	
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aw require	suois z	Completed								24a. Was autop	sy	24b. Were a	utopsy findings availat completion of cause of	ole of
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Division of Vita vite Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific	completely filled in by the funer	edical C	29a. Certifier (Check only one) Certifying Ph	ysician: To the base niner: On the base and manne	sis of examin	owledge, dea ation and/or i	ath occurre investigation	ed at the tim on, in my op	e, date and plac pinion, death oc	ce, and due to the curred at the time,	cause(s) date and	) and manner a d place, and du	as stated. ue to the cause(s)	
To the within 2	compli	Mec	29b. Signature and title of certifier	- ^				9c. License		1		te signed (Mor	nth, Day, Year)	
	1		Dendall	N-0	lell	W		DA	564	3	10/	30/0	5	
(	+		30. Name an address of person who	completed cause	of death (Ite	17/1	e, Print)	N.	charal-	3 es Sheef	1	300 Ctr	MD 2120	54
A Company	Sta	ite	31. Date filed (Month, Day, Year)	32, Re	gistrar's Sign	/	٥		- Will	0 440	1	JO2010	- 20100	- /
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygie pen 5 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Muriel May Campbell October 26,2005 7:30 P M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland 6. Sex 8. Date of Birth (Month, Day, Year) 10/1/1921 Funeral Days Hours 220-09-5309 1 □ M 2 😾 F 84 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 28a-f show 10d. Inside City Limits traumatic event, the Mudical Examiner must be notified at Director MD Baltimore Rosedale 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Cilizen of What Country? 8107 Rosehaven Road 21237 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 Yes 2X No þ Specify: 3X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ģ Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John F. Clowney Mary Helen Biddison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Campbell/Son 8107 Rosehaven Road Baltimore, Maryland 21237 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ital any injury or ott Burial 2 Cremation 3 Removal from State Parkwood 10/31/05 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 6415 Belair Road Baltimore, Maryland 21206 23a. Part1. Enter the disease, shock, or heart failure. Lis complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** CANCER disease or condition resulting in death) CAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of). sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☒ No 9 ☐ Unknown P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 5 structure lung disense. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed?
Yes 2 No Vital 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours efter deal To the Funeral Director 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number. City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) ţ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) no October 27, 2005 1)25 dos 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Anthony Riley MD 6601 W. Charles Street Towson, Maryland 21204 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State Registrar NOV 0 1 2005

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			1 - State of Maryland / Dep	partment of Health and Mertificate of Death	Mental Hygie	2005 35166	
ì	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death	_
	/Media	al	Augusta Cenci  4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		28, 2005 4:35 A <sup>M</sup> 4c. County of Death	_
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	Funeral Director		5. Social Security Number 6. Sex 1 M 25 7. Age (In yrs. last birthday 103 Yrs.	/) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y 8/6/1902	9 Righolana (State or Comigs	7
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I	ocation		10d. Inside City Limits	_
	Maryl -f eho fir d e	to	MD Baltimore Towso			1 ☐ Yes 2☐No	
	ith the	Jirec	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?	
	s 23e	eral [	1801 Wendover Road	21234		U.S.A.	
136	be filed within 72 hours after death with the Maryland ital Hygiene. In a maturel, or Items 23e or 28e-f ehow event, it e Modical Examiner must be notified at	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 □ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 Hoo Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White	
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Baltimore,	permit. Pages 1 and 2 should be f Department of Health and Mental I Importent: If item 27 Is marked ot any injury or other treumetic ever		IAD Burial 2   Cremation 3   Hemoval from State	ematory or other place)		c. Location - City or Town, State	
	artmer ortent injury				110r-Dipr	Baltimore, Maryland Del Funeral Home Inc.	_
ñ	Dep Imp		16-4/	6415 Belair Road B	altimore,	Maryland 21206	•
			23a. Part1. Enter the disease of complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac of	or respiratory arrest	t, Approximate Interval Between Onset and Death	
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DIVISION		Certification;	4 Homicide determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)		City or Town, S		
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	To To COUT	~	29b. Signature and title of certifier	29c. License number	ĺ	Date signed (Month, Day, Year)	
	/		30. Name and andress of person who completed cause of death (Item 23a) (Type	Print)	· E	ktoby 28, 2005	_
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State of Maryland / Department of Health and Mental Hygiepen 05 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 2005 **Physician** Lillian Docherty Μ. 9:00p м Oct. 26, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ivy Hall Nursing Center Middle River Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month. Day Year) April 24, 1929 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 220-20-4971 1 □ M 2 🖫 F Maryland **Director** Usual Residence of Decedent perrit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or items 23a or 28a-f show any njury or other traumatic event, it a Medical Examinat must be natified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Middle River 1 ☐ Yes 2 ☒ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 563 Kingston Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 文 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify:White by 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Anderson Edna May Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Diane Barnes /daughter 563 Kingston Road Baltimore MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 10/28/05 Baltimore MD BayviewCrematory 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 21221 23a. Part1. Enter the disease, or shock, or heart failure. mot enter the mode of dying, such as cardiac or respiratory arrest, lications that caused the dealth Approximate Interval Between v one cause on Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical (or as a consequence of): Examiner I manay duede Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed 1 attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical en the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mop Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Waknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No certificate 2 No 1 Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: ို 1 ☐ Yes 2 X No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerei Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 0 0055171 28705 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SERASTIAN JOHN 3023 BALTIMORE MO 21224 CASTERNI AVENUE 31. Date liled (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2005

			For State Registrar	State of Maryland / D	epartment of Health and No Certificate of Death	lental Hygier	2005 35168
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Las Donald R. Digg 4a. Facility Name (If not institution, give 14 Buhrstone Co	S street and number)	4b. City, Town, or Location of Death	10	Nay Year 3. Time of Death 28 2005 10:50pM  Re. County of Death Baltimore
	Funeral Director		Usual Residence of Decedent	ØM 2□F 54 Y	rs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 3 / 1 6 / 1 9	51 Mary Tand
	rith the Marylar or 28e-f show	Director	MD Baltime		S Mills 10f. Zip Code	10g. (	10d. Inside City Limits 1 □ Yes 2 ☒No  Citizen of What Country?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Department of Health and Mental Hydiene. Importent: If item 27 is marked other then "natural", or Items 23a or 28e-f show any injury or other treumatic event. The Medical Eramin artment to Indifficat at once.	Completed by Funeral Director	14 Buhrstone Co	12. Was Decedent Ever in U.S. Armed Forces? 1	21117  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	USA  14. Race - American Indian, Black White, etc. African SpecifyAmerican
21215-0036	d within 72 hou giene. er then "nature , the Medicul E	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) 16a. (	Decedent's Usual Occupation Give kind of work done during most of work life. DO NOT use retired)  ift Coordinator	ring	Kind of Business/Industry all Corporation
Maryland	S should be filed and Mental Hygie is marked other sumatic event, II	To Be (	17. Father's Name (First, Middle, Last)  Samuel A. D  19a. Informant's Name/Relationship (	iggs		e (First, Middle, Maid A. Diggs al Route Number, City	
Baltimore, M	Pages 1 and 2 nent of Health int: If item 27 iny or other tre		Jewel A. Dyson  20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specific	20b. Place of l cemetery	BuhrstoneCourtOw Disposition (Name of crematory or other place)	Date 20c.	S MD21117 Location - City or Town, State Dutus, Maryland
Balti	permit. Departn Importe any inju		21. Signature of Puneral Service Licental	22 Name and Address of Facility W V	lieFunera ad Randai	Allome PA or B.C. Ilstown, Md21133  Approximate Interval Batween	
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8760, <	death certificate be executed a attending physician and der use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate dauge. Enter druotying Cause (Disease or injury that infitiated events resulting in death) Last	Due to (or as a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence			
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Records, P	neen		Part II. Other significant conditions of	ontributing to death but not resulting in	the underlying cause given in Part I.	1 V Yes	b use contribute to the cause of death?  2 No 3 Probably 4 Unknown
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of	ng Phys fter this ineral dii	2	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	1		ome 5 esidence 28d. Describe how in	6 □Other (Specify) jury occurred
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)	To the Ho within 24 t To the Fu completely	Medical	(Check only one)  29b. Signature and title of certifier  Manual	niner: On the basis of examination and and manner stated.  M. Wrune, M.	/or investigation, in my opinion, death occur 29c. License number D1:787	3 N	Date signed (Month, Day, Year)  OVE When 1 2005
	() Sta	ate	Marshall A. L 31. Date filed (Month, Day, Year)	completed cause of death (Item 23a) (10 CV) (1	(yps. Print) Verth Charles	St. Bal	timere, MD 21209
	Regist	rar	NOV 0 1 2	005 Rages M	South a		

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			1- State of Maryland / Department of Health and Certificate of Death		2000	35169
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	/Medic			10	7-8 05	7.45 AM
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	<b>-</b>		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	s. 8. Date of Birth	Daum	The County
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			Usual Residence of Decedent	1404,0	, 1775	170
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	e-f s	흕	MD Baltimore Dundalk.			1 □Yes 2 ☑ No
	or 28	Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What C	ountry?
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₹	permit. Pag Department Importent: any injury c		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address i Facility	31/05	Daltimor	L, MD
B	permit. Departr Import any inj		Peter I ash Bradley - Ash to	N FUNETO	1 Home	, P.A.
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia	ac or respiratory arm	Rd 2/22	Approximate
8	Waste State		snock, or near tailure. List only one cause on each line.		1 .	Interval Between Onset and Death
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Ta	artific ctor.	Be (	os Warner and The Control of the Con	eath (Check only on		
	hysic nis ce I dire	To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing	Home Reside	ance 6 Other (Spe	cify)
Division of	ng Pl fter tl mera	:io	27. Manger of Death  28a. Date of Injury (Month, Day Year)  28b. Time of Injury at Work?	28d. Describe ho	ow injury occurred	
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	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director.	Med	one) and manner stated.  29b. Signature and title of certifier 29c. License number			
	F ₹ 5 8	_	255. Signature and this of softmen	,	9d. Date signed (Mont	n, Day, Year)
			10000 1000		10/28/0	>
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KMSTINE SALVO 9524 Belair Rd Balt	mare	110 71	236
	Sta	te			-1	
	Registr	-	31. Date filed (Month, Day, Year)  NOV 0 1 2005			
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State of Maryland / Department of Health and Mental Hygier 0 0 5 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year John 200 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Tours, or Location of Death 4c. County of Death **Examiner** Baltimor timo, ledical If Under 24 Hrs. 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days 1**X**M 2□ F Director 212-20-7566 78 April 30, 1927 Maryland Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show 1 ☐ Yes 2X No Maryland | Harford Joppatowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 570 Renee Drive Apt B 21085 USA be filed within 72 hours after death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 157 Yes 2 □ No If 79s, Give Year or Dates: WW T Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced W II White al Hygiene. d other than "natura avant, the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Custom Glass and College (1-4or 5+) Elementary/Secondary (0-12) Owner/operator Canvas ilth and Mental Hygir 27 is marked other r traumatic evant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clarence Edwin ပ Eney Gertrude Arlis Spurrier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Shirley E. Eney -Wife 570 Renee Drive Apt B, Joppatowne, MD 21085 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of h Important: if ite any injury or ot once. 2/11 C/6m 1X Burial 3 □ Removal from State A Dother (Specify Garrison Forest VA Cem. 11/02/05 Owings Mills, MD 21. Sign 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death and, enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hook, or heart failure. List only one cause on such line. Immediate Cause (Final DIration Physician disease or condition resulting in death) /Medical Due to (of as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed ig physician and as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No the 9 Unknown ٥ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? has l certificete 2 10 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 2 P 1 🗌 Yes 1 Dinpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Mann 1 D 1 L atural T Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) vithin 2 To the 29b. Sign who completed cause of death (Item 23a) (Type, Print) Ballimore, MD Greene 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 1 2005 Registrar

			For State Registrar	State of Maryland		irtment of F tificate of			one 005	35172
	Physicia		1. Decedent's Name (First, Middle, Last) Charles Hen	ry Furnan	ders	JR.		2. Date of Death Month	Day Year 30 - 3005	3. Time of Death
	/Medic Examin Funeral Director	er	4a. Facility Name (If not institution, give Future Care  5. Social Security Number 6. Set	street and number) Old Court		/	La 1/5 to Location of Death  (a 1/5 to Location 1/5 to Locatio	8. Date of Birth	Battin  9. Birth	1
	Maryland -f ahow		Usual Residence of Decedent  10a. State 10b. County  MD Baltim	1 1 1	Town or Lo	cation Sor Mi	7/			10d. Inside City Limits 1 ☐ Yes 2 No
	with the 3s or 28s	Funeral Director	10e. Street and Number Ridge 7805 Doe Ridge	e Drive		10f. Zip Code	244	109	g. Citizen of What Cou	intry?
920	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f ahow ha Madical Examiner musi be notified a	b	11. Marital Status  1  Never Married 2 Married 3  Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of I f Yes, specify Cub	Hispanic Origin? (Sp ean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Bl	
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Division of Vital Records,	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1t Natural 5 Pending investigation	Hospital: 1   Inpatient 2    28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Inju	ther: 4 Nursing H	th (Check only one ome 5 Resider 28d. Describe how	nce 6 Other (Spec	ify)
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	ha Hospit in 24 hours ha Funera pietely fille	edicai	29a. Certifier (Check only one) 2 Madical Exam	rsician: To the best of my kno iner: On the basis of examinal and manner stated.	wledge, death tion and/or in	h occurred at the t vestigation, in my	time, date and place, opinion, death occur	and due to the car red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	richmo		D	32/58		d. Date signed (Month	5
	10		Tyotin Par	ompleted causa of death (Item	23a) (Type, 21 N	Print) Luta	u St, #4	07 Bal	timore, Mi	0 21201
	St. Regist	ate rar	31. Date liled (Month, Day, Year)	2005 32. Registrar's Signa	ture	position		/		

			For State Registrar	State of	Maryland		artment of H tificate of L		nd Mental Hyg	giene Reg. No.	05	35173
d			1. Decedent's Name (First, Middle, Las.	)					2. Date of Dea	Day	Year	3. Time of Death
	Physicia /Medic		Martina	Feath	erstone				Octobe		2005	6:15 A M
	Examin		4a. Facility Name (If not institution, give		nber)		4b. City, Town, or		Death		inty of Death	
St			446 New Bridge Ro		7 // 10	and the Contraction of		ig Sun	Hrs. 8. Date of Birt		cil	alana (State or Famina
	Funeral		5. Social Security Number 6. Sec. 272–14–1204	X □M 27X□F	7. Age (In yrs. Ia Q	8 Yrs.	Months Days		Min. April 8	Year) 191	Cou	place (State or Foreign ntry) 1ana
	Director		Usual Residence of Decedent						APLIL	, 171	/ IIId	Tana
	/land		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	Mar	to	Maryland Cecil			Risi	ng Sun					1 ☐ Yes 2X No
	or 28	Directo	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	intry?
	15 will 23 a. 23 a		446 New Bridge Ro	ad			21	911			SA	
	r dea	Funeral	11. Marital Status	Armed For		5. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origi n, Mexican,	n? (Specify Yes or No Puerto Rican, etc.)		Race - Ameri Black, White,	
9	or it	<b>by</b> Ft	1 Never Married 2 Married	1 ☐ Yes If Yes, Giv	е -		1 ☐ Yes 2 💢 No	Specify:		Sp	ecify: Wh	ite
Ś	filed within 72 hours after death with the Maryland Hygiene. International control of the market of the work ent, the Medical Examinat must be notified at	g pa	3 Widowed 4 □ Divorced  15. Decedent's Ed	Year or Da	105.	16a. Dece	dent's Usual Occupa	ation		16b. Kind o	of Business/Ir	ndustry
<u>.</u>	in 72 in 72	Completed	(Specify only highest grad	de completed)	4==5-1	(Give	kind of work done of DO NOT use retired	furing most of	of working			,
7	filed withi Hygiene. other then ent, tre M	E	Elementary/Secondary (0-12)	College (1	-40r5+)	В	eautician			Sel	f Empl	oyed
2	Hyg othe	0	17. Father's Name (First, Middle, Last)					18. Mother	s Name (First, Middle,	Maiden Su	mame)	
Ö	uld be Aental rked c	To B	John Bishop						Mary Coles			
a	2 should be and Mental le marked o raumatic eve		19a. Informant's Name/Relationship (7	ype, Print)		19b. Maili	ng Address (Street a	and Number	or Rural Route Number	ar, City or To	wn, State, Zi	p Code)
_	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.  If Health and Mental Hygiene "naturel", or Items 23a or 28a-1 ehow them 71a marked other then "naturel", or Items 23a or 28a-1 ehow other traumatic event, Ita Meulcal Examinar must be notified at		Daniel Feathersto	ne, Sor				e Road	l Rising Su			
e	of He		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐	Removal from	00	ace of Dispo emetery, crei	sition (Name of matory or other plac	· 1	Date		on - City or T	
Ě	Pages ment of ant: If it ury or o		4 ☐ Donation 5 ☐ Other (Specify	)			ematory I		.0/31/05	Balt	imore,	Maryland
Baltimor	permit. Pages 'Department of Himportant: If Ite eny Injury or of once.		21. Signature of Funeral Service Liben	500		(	Name and Address Cramation	Socie	ty Of Mary	land	Inc.	1 04000
	THE STATE OF THE S		Thomas Gregor 23a. Part 1. Enter the disease, or comp	U dications that c	aused the death				Road Baltifi ardiac or respiratory a		Maryla	Approximate
			shock, or heart failure. List only	one cause on e	ach line.	11	11 0					Interval Between Onset and Death
< a	Physician /Medical		disease or condition resulting in death)	4.	or as a consequ		iddly (	ance	W			
	Examiner			Due to (	or as a consequ	rence or).						
	The state of the s	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (	or as a consequ	ience of):						
	uted d ansit	Examine	Cause (Disease or injury that initiated events	C								
Ď	exec an an rial-tr		resulting in death) Last	Due to (	or as a consequ	uence of):						
3/60	cate be executed bhysicien and the burial-transit	dicai		d								
õ	ng ph	Med	IF FEMALE:									
X P P	eath certific attending p	an/	23b. Was decedent pregnant in the past 12 mg/aths?	1 Live b	come of pregna- pirth 2 Petal	death 3	Ectopic pregnancy	,		<sup>1</sup> 23d	. Date of deline Month	very Day Year
o.	e dea	Sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregn 9□Unkn	nant at time of de own	eath 5[	Other (specify)					
<u>.</u>	The law requires thet the death certific tie hes been signed by the attending p page 2 should be detached for use as	Physician/Me	Part II. Other significant conditions of	ontobuting to de	eath but not resu	ulting in the u	inderlying cause give	en in Part I.	23e. Did t	obacco use	contribute to	the cause of death?
JS,	ires ti signe	Completed by	August A	tery D	lsease	g			10	Yes 22N	Io 3 ☐ Pro	bably 4 Unknown
Ö	w require been si should	etec	Notac P X		1 7	i Lala	mall	11.0	24a. Was	an   2	Ab Were aut	topsy findings available
ě	e taw hes l	mpi	NOW HAUM O	pence	NO NI	work	o men	VIV	auto		prior to co	ompletion of cause of
a									1 ☐ Yes	2 <b>X</b> No	1 🗆 Yes	2 No
Ħ	hysiclen: The law his certificate hes t I director, page 2 s	Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatie	nt 3 DOA Oth	05	of Death <i>(Check only c</i> sing Home 5 Resi		Other (Spec	.6.1
ö	Physic this seal d	To To	27. Manner of Death		of Injury th, Day Year)	28b. Time o			28d. Describe			<i>ay</i> )
o	th. : After s funer	tio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		th, Day Year)	Injury		k? Yes 2 □ N	lo			
Division of Vital Records,	or Attendi after death. Director: A in by the fu	Certification:	3 Suicide 6 Could not b	28e. Place	of Injury - At ho	me, farm, st	reet, factory, office		28f. Location ( City or To		lumber or Ru	ral Route Number,
á	s after if Direction by	Sert	4   Horricide	Duna	rry, etc. ( <i>apecn</i> )	*)			ony or 10	www, Otato)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificion properties on the funeral director.		29a. Certifier (Check only 2 Medical Exar	ysician: To the	best of my kno	wledge, dea	th occurred at the tin	ne, date and	place, and due to the n occurred at the time,	cause(s) an	d manner as	stated. to the cause(s)
	To the Hwithin 24 To the Fi	Medical	one)		ner stated.							
	To To Com	2	29b. Signature and title of certifier	00			29c. Licens	le unwoer	925		igned (Month	
,			The me	oke XX	5		D-C	10 72	700	101	31/05	
1			30. Name and address of person who		se of death (Item	1 23а) (Турв	Print) M	.0	21911- ()	848		
	4 CA	210	31. Date filed (Month, Day, Year)	7eet 32.	egistrar's Signa	HAS A	carte	1	of In	0 10		
	31	ate	NOV 0 1	UUD	Carlotted de	and the						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieneo For State Registrar Certificate of Death Reg. No. cedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 10:40 AM october 2005 /Medical 4c. County of Death ecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner none 9. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day) **Funeral** -30 Days Months Hours 1□M 200 F Yrs. Director and Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits creat: if item 27 is marked other than "natural; or items 23a or 28a-f show injury or other traumatic event, the Medical Examin or other traumatic event, the Medical Examin or must be notified at 1 Yes 2 No Funeral Director 10e, Street and Number 10f. Zin Code 10g. Citizen of What Country? 10 Was Decedent Eyer in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 No 1 🗆 Yes Specify. þ Specify: 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nit. Pages 1 and 2 should be filed within sitment of Health and Mental Hygiene. Crtant: if item 27 le marked other than ' College (1-4or 5+) Elementary/Se endary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother 's Name (First, Middle, Maiden Sumame) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or 20c. Location - City or Toylor, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Durial 2 □ Cremation 3 Removal from State Baltimore 4 ☐ Donation 5 ☐ Other (Specify) permit.
Departn
Imports
any inju 21. Signature of Funeral Service Licensee 22. Name and Address of Facility chapel of sin belle mD 23a. Part1. Enter the disease. ons that caused the dea Approximate Interval Between Onset and Death amplif Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. 1st only Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed C. Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 Live birth 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 IDNo Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 2 12 No 3 Probably 1 Yes 4 MUnknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has 2 2 No 2□ No 1 ☐ Yes 1 Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner: Hospital: 1 ☐ Inpatient 2 PER/Outpatient 3 ☐ DOA Other: 2 No 1 🗌 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death death the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel D Hospitai 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the

Registrar

State

29b. Signature and little of certifier

30. Name and a dress person who completed suse of death (Item 23a) (Type, Print)

1 2005

M.D.

INSEL

DHMH 17 Rev 1/2001

**ORIGINAL** 

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32. Registrar's Signature

29c. License number

37280

AVEN BLUD, STE 206,

29d. Date signed (Month, Day, Year) 10/28/2005

			1 - For State Registrar	State of M	larylar	nd / Depa		t of H	ealth a	and M	ental Hy	Reg. No.		35175
	Physici	an	1. Decedent's Name (First, Middle, La Marguer:	·	reel	and				1	Month Ictober	Day	Year	3. Time of Death 3:50 a M
	. /Medic Examin		4a. Facility Name (If not institution, given the Crest			unu		Town, or	Location o		oc coper		y of Death	
	Funeral Director		214-40-4856	Sex 7. A 1 □ M 2 □ XF	ge (In yrs. 87	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Da)	1918	9. Birth	place (State or Foreign nto) yland
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
:	e Mary ta-fsh	ctor	Md. Baltimo	re	Ba	ltimore	3							1 ☐ Yes 2 ☐XNo
	th with th	al Director	10e. Street and Number 53 Dendron Cou	rt			10f. Zig	2123 <sup>4</sup>	+			10g. Citizen of USA		ntry?
2-0020	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Separates it is marked other than "natural", or items 23e or 28e-f show any injury or other treumatic event, the Madical Examinar mast be nullised an once.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Deceden Armed Forces 1  Yes 2  if Yes, Give Year or Dates	? KNo		Was Dece If Yes, spe 1  Yes			gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)	14. Ra Bta Speci	ce - Ameriack, White,	
0-617	ithin 72 ho 1e. Imedical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ade completed)  College (1-4or	5+)		kind of wo DO NOT u	rk done d se retired)	ition uring most	of working	ng	16b. Kind of E		dustry
7	lled wi Tygien ther th		17. Father's Name (First, Middle, Lasi	5+		Schoo!	l Tea	cher	18 Mother	r's Name	(First, Middle,	Educat		
yiand	ould be f d Mental H narked of natic ever	To Be	Newton Johnson			405 14-75		(5)	Loui	se	Talbert	- Au		
, Ma	and 2 st ealth and n 27 is n		Mrs. Myra Darden/			53	Dend	ron (	Court		timore,			Code)
	ages 1 nt of Ho :: N iter		20a. Method of Disposition 1 Burial 2 XCremation 3		9	Place of Dispo cemetery, crer				<sub>0-28</sub> -	ate	20c. Location		
baltimol	rmit. Partme partme portent y injury		* 4 □Donation 5 □ Other (Special Service Lice		LIT	11top S					l Home,	Towsor	1, 110	•
מ	82589		23a. Part1. Enter the disease, or con	28			1050	York	Rd.	Tows	on, Md.	21204		Approximate
	Physician /Medical Examiner	er	shock, or heart failure. List only tmmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Due to (or a	s a consec	tage quence of):			hia					triterval Between Onset and Death
6/00,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Diseses or injury that initiated events resulting in death) Last	c	s a consec	quence of):								
.O. BOX 0	w requires that the death certifics been signed by the attending pt should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. tf yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fete	el death 3	Ectopic pr Other (sp						ate of delive	ery Day Year
cords, r	en signed I	þ	Part II. Other significant conditions Dichetes me	contributing to death						allous				ne cause of death? pably 4 🖽 nknown
n necc	sician: The law re certificate has be lirector, page 2 sho	Completed							-		24a. Was a autop: perfor	med?	death?	psy findings available mpletion of cause of 2 No
7 Kg	Physician: rthis certifica ral director, I	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:		150.0		Othe			(Check only or			
5	this raid	n: To	27. Manner of Death	28a. Date of In (Month, D		28b. Time of Injury		8c. Injury Work	4 Up dur		e 5 ☐ Resid 8d. Describe h			у)
DIVISION	To the Hospitel or Attending Physician: The within 24 hours after death.  To the Funerel Director: After this certificate h completely filled in by the funeral director, page	Certification:	1  Accident	pe 28e. Place of Ir		ome, farm, str	М	1 🗆 Y	es 2 N		8f. Location (S City or Tow		ber or Rura	ll Route Number,
5	spitel or nours afte nerel Die filled in		29a. Certifier 1 Destifying Pl	hysicien: To the bes	t of my kno	owledge, death	occurred	at the time	e, date and	i place, ai	nd due to the c	ause(s) and m	anner as s	tated.
8	the Ho hin 24 the Fu npletely	Medical	(Check only 2   Medicel Exer	miner: On the basis and manner s	of examina	ation and/or inv	vestigation	, in my op	inion, death	n occurre	d at the time, o	late and place,	and due to	the cause(s)
	0 1 W. T	-	29b. Signature and title of certifier		Mi			. License	number G 4 (	<i>f</i> _		29d. Date signe		
			30. Name and address of person who				Print)		)			OC 1846	1, 2	6,2005
			Anne Monics  31. Date filed (Month, Day, Year)	8 800 32. Redis	(yc. (	ther	Boo	leve	wa	A	actille	CIM, o	512	-34
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	Di		1. Decedent's Name (First, Middle, L					2. Date of Death Month		3. Time of Death	
	Physicia /Medic		George Edgar Fay October					23, 2005	5:27а м		
	Examin	er	4a. Facility Name (If not institution, g Genesis Elderca				Location of Death		4c. County of Death		
	Funeral		Social Security Number 6.	Sex 7. Ag	ge (In yrs. last birthda		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		thplace (State or Foreign	
	Director		218-36-2160	1 <b>X</b> M 2□F	64 Yrs.	I Suy S	110010	Sept. 1,	, <del>1914</del> Man	ryĺand	
036	yland wow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location							10d. Inside City Limits	
	e Mar la-f st	ctor	Maryland Baltimore Co. Middle River								
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	be filed within 72 hours after death with the Maryland tal Hygiene id other than "natural", or Items 23a or 28a-f show evant, I're Madical Examical must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces	X No 1 ☐ Yes 2 No Specify:			Rican, etc.)  Black, White, etc.  Specify: White			
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12	filed within 72 Hygiene. other than "nai ant, II e Micdic	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver A					Amorican	merican Asphalt		
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Maryland 21215-0036		To Be	John F. Fay		-		Erma	Phannon	stiel		
lar)	2 sho and h is me	ĺ	19a. Informant's Name/Relationship						City or Town, State,		
	s 1 and 2 should if Health and Mer itam 27 is marke othar traumatic	. 3	Mrs. Shirleyann 20a. Method of Disposition	Fay / Wife	20b. Place of Dis	05 Tailspi	1 -		iver, MD 20c. Location - City or	21220 Town, State	
10 10	Pages nent of int: if it		1 XBurial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe			ematory or other place Park Cemet			Baltimore,		
Baltimore,	permit. Pages 'Department of the Important: If its any injury or of once.		21. Signature of Funeral Service Lic						. Dundalk, M		
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			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death								
	Prrysician /Medical		Immediate Cause (Final disease or condition resulting in death)		ER CAP N s a consequence of):	ic Reg	IRATOR	Y FAI	LURUS		
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	ait sit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or as a consequence of):						
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8760	icate be executed physician and s the burial-transit	dical		d MORBID OBESITY					<b></b>		
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O.	t the d by the tachec	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown							
	res tha igned l	by	Part II. Other significant conditions	-				23e. Did toba	acco use contribute to	the cause of death?	
ord	w require been si	eted	- CHRONIC		AZ /NO		oncy	-			
Records,	he law e has l ige 2 s	Completed	DIABET	=3 MI	ELLITIUS			24a. Was an autopsy perform	prior to death?	stopsy findings available completion of cause of	
Vita		a	CHRONIC. 25. Was case referred to medical	DEEP	valous	THROM	26. Place of Death			2 No	
	Physici this ce al direc	ToB	examiner? 1 Tyes 2 No	Hospital: 1 Inpati	ient 2□ER/Outpati		4T Nursing Ho		nce 6 Other (Spe	cify)	
Division of	To the Hospital or Attanding Physician: within 24 hours after death.  To the Funaral Director: After this certifical completely filled in by the funeral director,	lon:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury a <i>y Year)</i> 28b. Time Injury	Wor		28d. Describe hov	w injury occurred		
/isi		fical	3 Suicide 6 Could not be determined determined 28e. Place of Injury - At home, farm, street, factory, office 28f.						Location (Street and Number or Rural Route Number,		
		Cert	4 Hornicus Building, etc. (Specify)								
		Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	vithin To the compl	Me	29b. Signature and title of certifier	DR. M	IAW N. DE	29c. License number		29	d. Date signed (Mont	Date signed (Month, Day, Year)	
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			30. Name and address of person when $6040$	no completed cause of HARFO	a - n	Print)	BALTIMO	ore 1	MD 2/2	14	
	Sta		31. Date filed (Month, Day, Year)	32. Regist	trar's Signature						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Ragistrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 274 8405 Ditobes /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner town
If Under 24 Hrs. If Under 1 Year timos 10 Security Num Number 8. Date of Birth (Month, Day, Year) AUG. 6, 1927 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min Months Days Hours 1 M 2 □ F Yrs MD 220-20-8230 78 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28e-f show other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 ▼ No Director BALTIMORE RANDALLSTOWN 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA or iteme 23a 21133 4008 STARBROOK ROAD 2 should be filed within 72 hours after death and Mentat Hyglene. Is marked other than "natural", or Iteme 23. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (XYes 2 □ No WWII If Yes, Give Year or Dates: NAVY Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify. þ 3 ☐ Widowed 4 ☐ Divorced WHITE NAVY Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALESMAN **EDUCATION** 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Importent: if Item 27 is marked oth any injury or other traumatic event Quee. 17. Father's Name (First, Middle, Last) Be FELDMAN REBECCA **GETZ** FRANK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4008 STARBROOK ROAD - RANDALLSTOWN, MD 21133 NATALIE J. FELDMAN / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/30/2005 ROSEDALE, MD PETACH TIKVAH CEM. 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Trole disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and thed for use as the burial-transit be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 Klo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Impatient To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) his Date of Injury (Month, Day 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide determined 4 T Homicide within 24 hours a To the Funerel C 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29c. License number 29b. Signature and title of certifier ho completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

NOV 0

32 Registrar's Signature

2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear 9 RESS **Physician** CHARLES AMES 2005 22=18 M OCTOBER 25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** IPPER CHEJAPEACE MODICAC CONTAN HALFORD 3 ELAIN If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1**√**M 2□ F Hours Months Davs 64 214-40-7990 Director July 30 1941 MD Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f ehow item 27 is marked other then "naturel", or items 23a or 28a-f show other traumatic event, the Madical Examination must be notified at 1 ☐ Yes 2√2 No Director MD Jarrettsville Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4048 Born Rd. 21084 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status illed within 72 hours after 1 ☐ Never Married 2 X Married 1 Nes 2 I If Yes, Give Year or Dates: 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Pipe Fitter Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be fi h and Mental H I Is marked ott Be James Thomas Gress Margaret Conway ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Thomas J. Gress/Son 120 Philosophers Tr. B6, Chestertown, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 6 Department of Important: If eny injury or one. Crestlawn Cemetery 10/29/05 Marriottsville, MD 21. Signaturi (1 - un a Sapyica Licensee <sup>22. Name and Address of Facility</sup> Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 Michael J. Flagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician HASCUA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? ö Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a Division of Vital Records, P.O. 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 QUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No. 24a Wasan certificate has b 1 Tyes 2 No or Attending Physicien: within 24 hours after deam.

To the Funeral Director: After this certific 25. Was case referred to medical Be 26. Place of Death Check only one examiner? 1 🖾 ¥es 2 🗆 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Outpatient 1 Dinoatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Accident Injury 5 Pending 1 Tes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and que to the cause(s) and mainten as stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

State

30. Name an

31. Date filed (Month,

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oress, James

Goods

M. O.

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address of person who completed cause of death (Item 23a) (Type, Print)

2005 32. Registrar's Signature

JEKENS ...

M.D.

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OCT 26, 2005

MDAD 1, MONWM MD 21093

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	/Medic	al	Joseph B. Grea			Ab City Town	ar Legation of Death	Octobe:			0242 <sup>M</sup>
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ryla	hould d Mer marke matic	2	John Kauffman  19a. Informant's Name/Relationship (		19b. Mailir	a Address (Stree		se A.			Code) 21236
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ē.	es 1 a of Hez r Item	16	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 💆	20b. P	Place of Dispo	sition (Name of natory or other pla	ace)	Date	20c. L	ocation - City or T	own, State
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Ball	becuted The permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland by S. Department of Health and Mental Hygiene.  Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show and S. Department of the strangic event, It is Madical Farm or Items and Department on the strangic event, Items and Department on the strangic event, Items and Department on the strangic event, Items and Department on the strangic event, Items and Department on the strangic event, Items and Department on the strangic event, Items and Department on the strangic event, Items and Department on the strangic event, Items and Department of Strangic event, Items and Department of Strangic event, Items and Department of Strangic event of Strangi		21. Signature of Funeral Service Licer	1500	/ K	aczorov	ess of Facility un	eral H	lome	P. A.	1. 21222
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	To the within	Σ	29b. Signature and title of certifier  29c. License number  OCME			29d. Date signed (Month, Day, Year)					
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	10		30. Name and address of person who		п 23а) (Турө,	rini) <b>III</b>	remi orre	ce Dal	CTHO	re, rary	Lana CIZUI
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State of Maryland / Department of Health and Mental Hygie 20 0 5 35180 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** OCTOBER 28, 2005 GOLD 11:43 A M RUTH FELDMAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPICE OF BALTIMORE-GILCHRIST TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) APR. 22, 1939 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1□M 2ਊF MD 66 213-36-7051 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 □ No Directo MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3021 FALLSTAFF ROAD #208-B 21209 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 12 ADMINISTRATOR RETAIL 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Is marked o **FELDMAN** LIPSITZ RITA MILTON 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau 5504 ST. ALBANS WAY - BALTIMORE, MD 21212 BENJAMIN FELDMAN / BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 10/30/2005 WOODLAWN, MD 4 ☐ Donation 5 ☐ Other (Specify) SHAAREI TFILOH CEM. 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER LUNG Physician month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dualto (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No certificate 1 ☐ Yes 2 No 1 TYes after death.

Director: After this certific
J in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 TYes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) us 025201 10 who completed cause of seath (Item 23a) (Type, Print) 30. Name and address of person N-Charles St. Balto MI 2120k BMC 6761 12 31. Date filed (Month, Day, Year) 32. Registrar's Signature State farts Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

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036	urs after dea of', or itema secultor re	by Fur	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 XX No If Yes, Give Year or Dates:	ver in U.S.	3. Was Decedent of H II Yes, specify Cuba 1 ☐ Yes 2 🏋 No	lispanic Orig an, Mexican, Specify:	in? (Specify Ye Puerto Rican,	etc.)	14. Race - Ame Black, White Specify:	
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Mary	s 1 and 2 should f Health and Men Item 27 ie marke other treumatic		19a. Informant's Name/Relationship (Ty PHILIP GROSSMAN			ailing Address (Street					
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Baltimore,	permit. Pages Depertment of I Important: if Its any Injury or o		4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service Licens		BALTIMO	RE HEBREW 22. Name and Addre	ss of Facility	SOL L	EVINSON	REISTERS N & BROS	, INC.
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	Physician /Medical Examiner		shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each line	θ.	SEPSIS.					Onset and Death
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,092	eath certificate be executed ettending physicien end for use as the burial-transit	cal Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence of):						
68	artificate ing phys e as the		IF FEMALE:	0	-	*****				201 5 / 1	
P.O. Box	at the death ce by the ettend stached for use	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	2 Fetel death	3 □Ectopic pregnanc 5 □ Other (specify) _	у			23d. Date of del Month	Nery Day Year
	ires that signed b d be deta		Part II. Other significant conditions co	ntributing to death bu	it not resulting in th	ne underlying cause given the second of the	ven in Part I.		3e. Did tobacco		the cause of death?
of Vital Records,	Physicien: The law requires that the death certifica tribs certificete has been signed by the ettending phrail director, page 2 should be detached for use as the	Completed by	Rocent left in	te, 60ch	arferie	myelof brache,	,		4a. Was an autopsy performed?	death?	atopsy findings available completion of cause of
Vita	ysicien: The iis certificete hi director, page	Be	25. Was case referred to medical examiner?	Hospital:	nt 2□ EP/Outp	atient 3 DOA Ot	her	of Death (Che		6 ☐Other (Spe	cifv)
	ing Phys After this uneral di	on: To	27. Manner of Death 1 Death 5 Pending	28a. Date of Injur (Month, Day	y 28b. Tin	ne of 28c. Inju		28d. D	escribe how in		
Division	or Attend ifter death Director: / in by the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc		n, street, factory, office		281. Lo	ocation (Street ity or Town, Sta		ural Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer	Medical Ce	(Check only 2 Medical Exam	iner: On the basis of	examination and/	death occurred at the to or investigation, in my	opinion, dea	th occurred at t	he time, date a	ind place, and du	to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier  30. Name and address of person who of the company of the	ageur	MO	29c. Licen	se number 428	8	29d. [	Cate signed (Mont	Sty 2005
	V		30. Name and address of person who o	completed cause of d	eath (Item 23a) (T	ype, Printy out	west	HUSPU	tal a	utg.	
		ate		32 Registra	ar's Signature	Scarle 3					
	Regist	ııaı	NOV 0 1 20	IUD   CENS	a per p	7		_			

				artment of Health and Me	ental Hygiene	2010 00102
		S	Decedent's Name (First, Middle, Last)		. Date of Death	3. Time of Death
	Physicia	_	Carol Christine Gatto	C	otober 27	
1	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
		Spall.	60 Right Wing Drive	Millde River	В	altimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		Date of Birth (Month, Day, Year	9 Birtholace (State or Foreign
	Director		220-62-2949 1 M 2X F 52 Yrs.	1	0/29/1952	Maryland
	and *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	danyli f eho	ō	Maryland Poltimore Middle Di	T. C. C.		1 ☐ Yes 2 XNo
	28a-	Director	Maryland Baltimore Middle Ri  10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
	3a or	ā	60 Right Wing Drive	21220	ī	S. A.
	ms 2:	era	11 Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Speci	fy Yes or No-	14. Race - American Indian,
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "netural", or Items 23a or 28a-f show supprignts: if Item 27 is marked other then "netural", or Items 23a or 28a-f show supplicitly or other traumatic event, I're Madical Examinar must be notified at an ance.	by Funeral	Amed Forces?  1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Ri  1 ☐ Yes 2 X No Specify:	can, etc.)	Black, White, etc.  Specify: White
Õ	2 ho	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation  e kind of work done during most of working	16b. ł	Kind of Business/Industry
21	thin 7	npie	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		
2	filed wi Hygien other th	S	4 Nurs			spital
<u>n</u>	d oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (	First, Middle, Maide	n Sumame)
<u>×</u>	ould Men Parke	<sup>2</sup>	Richard Gatto	Dorla	Welch	T 0 1 7 0 1 1
Na	12 st h and 7 is n traun			ling Address (Street and Number or Rural)	_	17 - 29 - 1
	1 and Healt em 2			ongeron Drive Midd position (Name of paratory or other place)  Da		Maryland 21220  Location - City or Town, State
Baltimore,	Pages nent of l ant: if its		1 E3 Buriai 2 Cremation 3 Chemoval from State	1 11/1		
	artme ortan injury		21 Signature of Funeral Service Licensee	22. Name and Address of Facility		dle River, Maryland
Ba	Depa Impo eny i		Michael C. Jallian Sc. B	Bruzdzinski Funeral 407 Old Eastern Ave	Home PA nue Esse	x. Marvland 21221
	section .		23a. Part1. Enter the disease or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final	nnia Unspecifi	6 9	Onset and Death
1	/Medical-		resulting in death)  a.  Due to (or as a consequence of):	11.000		Ministe to
18	Examiner		Sequentially list conditions. b. Start Thro	wpo7n		hours
	p ii	iner	Sequentially list conditions, if any, leading to in interdate cause. Enter Underlying Cause (Disease or injury	· Common All	TO WELL	sease Months
	and I-tran	Examiner	that initiated events resulting in death) Last  C. Due to (or as a consequence of):	te Coreva, A	150	reals Legalus
8760,	cate be executed ohysician and the burial-transit			.7	77.	
687	ficate physics to the	edic	d			
Box	The law requires that the death certific ate has been signed by the attending p page 2 should be delached for use as	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of delivery
	e deat he att	sicia		Other (specify)		Month Day Year
P.O.	d by t	P.	Part II. Other significant conditions contributing to death but not resulting in the	underhine cours aven in Dert I	23a Did tobacco	use contribute to the cause of death?
	signed d be de	٥	Must ble Sclerosis	underlying cause given in Faith.	1 Yes 2	
50	w requir been si should	etec	3210			
3ec	has has ge 2 s	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
a	n: Th licate r, pag		Of War and the state of the sta		performed? 1 ☐ Yes 2 ☑ N	o 1 Tes 2 No
₹	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner:  1 □ Yes 2 X No  Hospital: 1 □ Inpatient 2 □ ER/Outpatie	26. Place of Death (		6 ☐Other (Specify)
o	y Phy ar this eral d	n: To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 28	d. Describe how inju	
<u>io</u>	Attending r death. ector: After by the fune	atio	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	M 1 Yes 2 No		
Division of Vital Records,	er der recto by th	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 28	If. Location (Street a	and Number or Rural Route Number, te)
	urs after rrai Dire					
	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier  (Check out)  (Check out)  (One)  1 Certifying Physician: To the best of my knowledge, dea  (Check out)  2 Medical Examinar: On the basis of examination and/or i  and manner stated.	ath occurred at the time, date and place, an investigation, in my opinion, death occurred	id due to the cause(: I at the time, date an	s) and manner as stated. Indicate, and due to the cause(s)
	To the To the compl	Me	29b. Signature and Little of cerrifich	29c. License number	29d. D	ate signed (Month, Day, Year)
	101		N A A THOUGH	D1/113	Oc	T 28, 2005
	4		30 Name and address of person who completed cause of death (Item 23a) (Type Paul Schu, 42tz M.D. 357a	> Needand Rel	21218	3
	Sta		31. Date filed (Month, Day, Year)  32. Egistrar's Signature	1		
4	Regist	rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 0 1 2005	pardi		

10/31/2005 ohn Getter Man 11:5534

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item 18 per fh 2849 11-17-05 vt
State of Maryland? Department of Health and Mental Hygiens 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** October 31, 2005 John William Getterman 11:55 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oak Crest Village Care Center Parkville Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 217-03-7985 1**X** M 2 ☐ F 89 Yrs. Director 10/12/1916 Maryland Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.
Item 27 is marked other then "naturel", or Items 23s or 28s-f show other traumatic event, the Medical Expirator into to totilised. MD Baltimore 1 ☐ Yes 2 ☑ No Parkville Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Walther Blvd. Apt 3210 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 23€ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Liquor Distributer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William A. Getterman Christina G. Main 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is in eny injury or other traum once. Iris A. Getterman/Wife 8800 Walther Blvd. Parkville, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State Lorraine Park 11/3/05 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 6415 Belair Road Baltimore, Maryland 21206 Mino Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Brain tumor Lerebeller disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consuluence of) ig physician and as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. by Physician/Medical esn IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ō Month 4 Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown signed t Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Diahetes 1 Yes 2 No 3 Probably 4 Unknown mellitus Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate 1 Yes 2 No To the Hospitel or Attending Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Matural 5 Pending Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 10-01 058646 October 31,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) us Ither Boulevard Monics 8800 32. Registrar's Signature 31. Date filed (Month, Day, Year) State ORIGINAL NOV 0 1 2005 Registrar

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 9:40AM 1 2005 orothi /Medical 4c. County of Deeth 4b. City, Town, or Location of Death Socility Neme (If not institution, give street end number) Examiner PALTI MORE ALTIMORE ntei If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) curity Number 7. Age (In yrs. last birthday) **Funeral** Min Months Deys Hours 1□M 2 5 Yrs tassaic Director Usual Residence of Decedent death with the Marylend 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No DALTMORE MI Funeral Directo TI MOR 28a-1 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 23a or 0103 88 Was Decedent Ever Armed Forces? 1 Dayes 2 No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. or items 11 Maritel Status e filed within 72 hours efter el Hygiene. 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. Specify: White. Completed by 4 Divorced 3 Widowed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) altimore eacher 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Be liaar ၉ 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Reletionship (Type, Print) MOSISIS 2106 BALTIMORE. aughter 20c. Location - City or Town, State Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other) Date Depertment of I important: If Ite any injury or of 1 Burial 2 □ Cremation 3 □ Removal from State Nather Men. Garden 4 ☐ Donetion 5 ☐ Other (Specify) limonium. 22. Name and Address of Facility MORE MD 21234 21. Signature of Funeral Service Licenses EVANS FUNSPALCHAPEL 8XXXX HARFORD Approximate Intervel Between Onset end Death Per 1. Enter the diseas- or complications if at caused t shock, or heart failure. List only one couse on each line death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Physician /Medical Immediate Cause (Pical diseese or condition resulting in death) Examiner Physician/Medical Examiner Ca Attending Physician: The law requires that the deeth certificate be executed physician end s the buriel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): P.O. Box 68760. Due to (or as a consequence of) ettending ph 23b. Did tobecco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 4 Onknown 3 Probably 1 ☐ Yes 2 ☐ No Division of Vital Records, þ 24a. Wes an eutopsy performed? 24b. Were autopsy findings available prior to Be Completed completion of cause of death? this certificate has rel director, pege 2 1 ☐ Yes → No 1 🗆 Yes 2□ No 25. Was cese referred to medical 26. Place of Death (Check only one) Other: Hospital: 2 No 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 3□ DOA 2 ☐ ER/Outpetient 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Death 28b. Time of Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident I Director: A investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours of To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Yeer) 29c. Lisense number 29b. Signature and title of certifier tem 23e) (Type, Print) 30. Name encleddress of person who completed cause of deeth 800 21 -37 31. Dete filed (Month, Dey, Yeer)

**DHMH 16 Rev 6/95** 

State

Registrar

32. Registrer's Signature

NOVO

2005

		1 - For State Registrer	State of Maryland	/ Depa	artment of H	lealth and Death		giene 005	35185
		1. Decedent's Name (First, Middle, I	.ast)				2. Date of Dea	ath	3. Time of Death
Physici /Medi		JUNE 1	L HINKLE				October		3:50 PM
Examir		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, or			4c. County of Deat	h
			Sex 7. Age (In vrs. las	a de la la de la colo	GLEN If Under 1 Year	BUR If Under 24 Hr	N/E s. 8. Date of Birt	A.,	4.
Funeral Director		219-30-1415	. Sex 7. Age (In yrs. las	Yrs.	Months Days	Hours Mir		y, Year) Co	hplace (State or Foreign funtry)
		Usual Residence of Decedent	70				JUNE	1, 1/33	AK 1CHND
anylan show	_	10a. State 10b. County		Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 █ No
ith the Marylar or 28a-1 show	Director		A. Co. GL	EN	BURK	IIE			
with t a or 2	Ö	10e. Street and Number	-01111 A		10f. Zip Code	1010		10g. Citizen of What Co	*
er death w Items 23a	Funeral	11. Marital Status	ERHILL RD.  12. Was Decedent Ever in U.S.	. 13.1		1060 ispanic Origin? (	Specify Yes or No- into Rican, etc.)	14. Race · Ame	·
s after death with the Maryla s or Items 23e or 28e-1 shou		1 ☐ Never Married 2 ☐ Married	Armed Forces?  1 ☐ Yes 2 No		f Yes, specify Cuba 1 ☐ Yes 2 ☑ No		irto Rican, etc.)		e, etc.
hours.	d by	3	If Yes, Give Year or Dates:		TU Tes 2120 No	Specify:		Specify: W	HITE
2 2 2	Completed	15. Decedent's (Specify only highest of	Education grade completed)	16a. Deced	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of w	orking	16b. Kind of Business/	Industry
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be filed within tal Hygiene. od other then event. If a M	Be C	17. Father's Name (First, Middle, La	st)	1 / 1 / 0	10 //		ame (First, Middle,		C0/4/-///· /
tally allowed with and Mental Hygiene. Is marked other the sumatic event.	To B		DR	IGGE	ERS	LOR	ETTA		HISKY
S 1 and 2 should f Health and Men item 27 is marke other treumatic		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ig Address (Street			r, City or Town, State, 2	
permit. Pages 1 and 2 Department of Health is Importent: If item 27 is any injury or other tre once.		TIM HINKLE,		280		NECK			MD 21619
Pages 1 nent of H int: If ite		20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3	Removal from State Cen	netery, crer	sition (Name of natory or other place		Date	20c. Location - City or	
it. Pa it. Pa rtmer rtent: njury		* 4 □ Donation 5 □ Other (Spe- 21. Signature of Funeral Service Lice	oify) MEAD	DWRI	SE MEM	PK. 10	-31-05	BALTIMOR	E, MD ERVICE P.A.
Deparmi Impo		21. Signature of Pulleral Service 2		1. W				LTO. MD	21225
		2 a. Part1. Enter the disease, or co	plications that caused the death.	Do not ent					Approximate
Physician		shock, or heart failure. List of	y one cause on each line.	1 /	200 Ca	viwen	a Con	и	Interval Between Onset and Death
/Medical		disease or condition resulting in death)	a.  Due to (or as a conseque	nce of):	DE CA	O TO BY	WI -	1	
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The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	hysician/Medical		10						
death certifica attending ph for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnand		Ectopic pregnancy			23d. Date of del	,
e dea the att	slcl	in the past 12 months? 1 \( \sum \text{Yes} \) 2 \( \sum \text{No} \)	4☐Pregnant at time of deal		Other (specify)			Month	Day Year
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sicien: The law scertificate has b lirector, page 2 s	Completed					<u> </u>	autop: perfor	sy prior to death?	topsy findings available completion of cause of
Bn: T tificat tor, pa	0	25. Was case referred to medical				26 Place of De	1 ☐ Yes eath (Check only or	2 X No 1 Yes	2 No
ysici is cer direct	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ EF	R/Outpatien	t 3 DOA Othe			ence 6 Other (Spec	cify)
ding Phys		27. Manner of Death  1 Aatural 5 Pending	28a. Date of Injury (Month, Day Year)	8b. Time of	28c. Injury Work	at c?	28d. Zescribe h	ow injury occurred	
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or At or At offer d Direct in by	Certification:	4 Homicide determine	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (S City or Tow	treet and Number or Ru n, State)	ral Route Number,
spitel	00	29a. Certifier 1 Certifying	Physicien: To the best of my knowle	edge, death	occurred at the tim	ne date and place	e, and due to the o	ause(s) and manner as	stated
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	(Check only 2 Medical Ex	aminer: On the basis of examination and manner stated.	n and/or in	estigation, in my of	pinion, death occ	curred at the time, o	date and place, and due	to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier			29c. License	4		29d. Date signed (Month	
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 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiege Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Lest) OCTOBER Day E9, **Physician** Year 201215 VIRGINIA HAGNER 9:47A /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner Center Baltimore Saint Joseph Medical Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** Days 1□ M XX F 219-32-7523 69 Yrs Director 04-30-1936 MARYLAND Usuel Residence of Decedent Pages 1 end 2 should be filed within 72 hours after deeth with the Marylend nent of Health end Mentel Hygiene. Int: If Item 27 is marked other than "natural", or Items 23e or 28e-1 show 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√XNo MD. BALTIMORE PARKVILLE Funeral Director 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 1702 OAKLEIGH COURT 21234 U. S. A. 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2XXXIVo
If Yes, Give 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status Black, White, etc. 1 Never Merried Married Baltimore, Maryland 21215-0020 1 ☐ Yes 🏋 No Specify: WHITE Specify: Completed by If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME YEARS 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Lest) Be HIRAM PLUMMER KATHARINE SHEOWMAN ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PAUL J. HAGNER (HUSBAND) 1702 OAKLEIGH COURT, PARKVILLE, MARYLAND, 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Depertment of h important: If its any injury or ot 1 ☐ Burial 2XXXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10+31-2005 TOWSON, MARYLAND, 21204 HILLTOP SERVICE CORP. 4 □ Donation 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 1050 YORK ROAD ( R.G.RUTH) RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD.21204 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Deer and Death **Physician** ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Immediate Ceuse (Final diseese or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner use es the bunal-transit or Attending Physician: Tha law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): resulting in death) Last To the Mospital or Attending Physician: Tha law requiras that the dewithin 24 hours efter deeth.

To the Funeral Director: After this certificate hes been signed by the a complataly fillad in by the funeral director, page 2 should be dateched if Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown HYPERTENSION Medical Certification: To Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? DIABETES MELLITUS 2 🗆 No 1 Ses 2 No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29e. Certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certified 12005 D51852 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) M. D. 76.6 32. Registrar's Signeture OSLER DRIVE, TOWSON, MARYLAND 21204 DAVID A. BRINKER 7601 31. Date filed (Month, Day, Year) State

**DHMH 16 Rev 6/95** 

Registrar

2005

Physic	an	1. Decedent's Name (First, Mic Tong C	ddle, Last) heung Ho	<u> </u>				2. Date of Month	D	ay Year	3. Time of Dec
/Medi Exami	cal	4a. Facility Name (If not institut				4b. City, Town,	or Location of			24, 2005 c. County of Deat	
Exami	iei	Sinai Hospita				Balti		500111			
Funeral Director		5. Social Security Number 212-31-4546	6. Sex 1 M 2 □ F	7. Age (In yrs. 64	last birthday) Yrs.	If Under 1 Yea Months Days		Hrs. 8. Date of (Month Novemb	Birth Day, Year		hplace (State or Fo untry) China
land		Usual Residence of Decedent  10a. State 10b. Cour	nty	10c. City	y, Town or Lo	cation					10d. Inside City L
Mary	to	MD Mont	tgomery		Bethes	da					1 □ Yes 2 5
ith the or 284	Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Co	untry?
s 23a		4521 East Wes				20816				R. China	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23a or 28a-f ehow any injury or other traumatic event. I'm Medical Examination must be multified at ange.	by Funeral	11. Marital Status  1 □ Never Married 2 M  3 □ Widowed 4 □ Divorce	Armed Fe	2 ₹ No	1	Vas Decedent of Yes, specify Cu ☐ Yes 2√ No		n? (Specify Yes or Puerto Rican, etc.	No-	14. Race - Ame Black, White Specify: Asi	e, etc.
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of Hei		20a. Method of Disposition			lace of Dispos	sition (Name of patory or other pla		Date		ocation - City or	
Page nent c int: if		1 ☐ Burial 2 ② © rematio 4 ☐ Donation 5 ☐ Other		State			, I	11/01/05	Ales	zandria i	Virginia
permit. Departn Imports any inju		21. Signature of Juneral Service	e Licensee		22	Name and Addr	ess of Facility	Loring By	ers l	Funeral 1	Directors
20 E E 9		Mests	Waro,		87	28 Liber	ty Road	i, Randal	.1sto	vn,Maryl	and 21133
		23a. Part1. Enter the disease, shock, or heart failure. L	or complications that of ist only one cause on a	caused the death each line.	. Do not ente	er the mode of dy	ing, such as ca	rdiac or respirator	y arrest,		Approximate Interval Between
nysician		Immediate Cause (Final disease or condition	Athe	rosclero	otic Ca	rdiovas	cular D	isease			Onset and Deat
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ne death cer the attendir thed for use	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live b	tcome of pregnar birth 2 Petal nant at time of de own	death 3 🗌	Ectopic pregnand Other (specify) _	e <b>y</b>		-	23d. Date of deliving Month	very Day Year
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	•	1 - For State Registrar	State of	Maryland	d / Depa <i>Cer</i>	rtment of H	lealth a	and Me	ental Hygie		5 3	35188
Physici	an	1. Decedent's Name (First, Middle, L	ast)						2. Date of Death Month	Day	Year	3. Time of Death
/Medic			Elizabetl		y Huff				October		005	1:30 P M
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id be fill lental H rked oth	To B	Charle	s Marsha	ll Beacl	hv				Eva Br	oadwat	ter	
and house		19a. Informant's Name/Relationship				g Address (Street	and Numbe	r or Rural	Route Number, C			Code)
if e, INTAILY INTAILY AT LEGATOROSO. Is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygene if the Marylan item 27 is marked other than "natural", or items 23a or 28e-1 show other traumatic event. I'm McJical Eracitier manter rolling at		Mary Amelia Hu	ff/ Daugl		1100	6 Ralsto	n Road	d Nor				and 20852
D d H iter		20a. Method of Disposition 1 X Burial 2 □ Cremation 3	☐Removal from S		ace of Dispo: metery, crem	sition (Name of natory or other pla	сө)			c. Location -	City or Tov	vn, State
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		snock, or heart failure. List on Immediate Cause (Final	y one cause on ea	ich line.								Interval Between Onset and Death
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VICAL I	e Co	25. Was case referred to medical					26 Place	of Dooth	1 ☐ Yes 2 🔀 (Check only one)	No 1	☐Yes 2	No No
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To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical		Physician: To the i aminer: On the ba and mann	sis of examinati								
To the within To the comple	Me	29b. Signature and title of certifier	> 11	1	- 1	29c. Licens	e number		29d.	Date signed	(Month, D	ay, Year)
		1 and	in JAK	JAR	MY		D213	392		Octob	er 26	, 2005
		30. Name and address of person wh	o completed cause	of dealin (Ite)n	23а) (Туре,	Print)						
		Patricia D. Kel	logg, M.I	1201	Seven	Locks R	oad #1	11 R	<u>ockville</u>	, Mary	land	20854
Sta Registi		31. Date filed (Month, Day, Year)	32. Re	gistrar's Signat	ure	2						
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State of Maryland / Department of Health and Mental Hygien 35189 Certificate of Death Reg. No. 1. Decedent's Name (First. Middle, Last) 2. Date of Death 3. Time of Death October 28 **Physician** Marie A.S. Kane 8:30 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore 6807 Barnett Road Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, MAR 14 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1□M 2XF Days Hours 93 NY 063-10-1741 Director Usuel Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c City Town or Location 1 ☐ Yes 2 No Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 6807 Barnett Road **USA** Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Black, White, etc. 1 Never Married 2 Married 1 Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DONOT use relired)

ng Distance Telephone Operator Elementary/Secondary (0-12) College (1-4or 5+) Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Schussler William Fmma Krueger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Kane - husband 6807 Barnett Road, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Inc 10/31/2005 Beltsville, MD 21. Signature of Funeral Service Licensee CAFA, Stephen D. Lohrmann, 8717 Green Fastures Drive, PA Towson, MD M00986 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit the attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year jo in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. λq should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No Hospitel or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one, Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 4 hours after death. death. 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C 12 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2 cause of death (Item 23a) (Type, Print) 30. Name and address of person who compl Amn 31. Date filed (Month, Day, Year) r's Signature State NOV Registrar

			1_ For State	State of Ma	ryland.		rtment of H			_	005	35190
	Den		Registrar  1. Decedent's Name (First, Middle.	( ast)		061	uncate or i	Dealii	2. Date of De	Reg. No.		3. Time of Death
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	/Medic		4a. Facility Name (If not institution,		1	1016		r Location of Death	10	40.0	County of Dea	th
	Examin	er	1 AVIAN HO	inktord	/		POIT	1 mare	MA		rounty of Boa	
	Funeral	100	5. Social Security Number 6	5. Sex 7. Age	(In yrs. last	birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	th	9. Bir	thplace (State or Foreign
	Director		215-34-6344	1 🕱 M 2 🗆 F	68	Yrs.	Months Days	Hours Min.	(Month, Da May 25,	y, Year) 1931	7 MA	rvland
594	P.		Usual Residence of Decedent									
	show	_	MD Ba	ltimore	10c. City, T							10d. Inside City Limits 1 ☐ Yes 2 XNo
	Ba-f	ecto		TUMOTE		Ess						
	a or 2	Dir	10e. Street and Number 131 Riversio	lo Dood			10f. Zip Code	224		-	en of What Co	ountry?
	after death with the Maryland or Items 23a or 28a-f show critical next be rediffed at	Funeral Director		12. Was Decedent E	ver in IIS	12 V	212		pecify Vac or No	USI	4. Race - Ame	arican Indian
_	Item	Ë	11. Marital Status  1X Never Married 2 Marner	Armed Forces?		IS. V	Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	.   '	Black, Whit	
200	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	_	1	☐ Yes 2 No	Specify:		5	Specify: Wh	ite
5	2 hor	ted	15. Decedent's	Education	1	6a. Deced	ent's Usual Occup	ation		16b. Kind	d of Business	/Industry
7	thin 7	pie	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+	-)			during most of world)	ang	Ral	to. C	0
V	er th	Completed	11th			Fire	man			.501		· .
<u>a</u>	be file tal Hy d oth	Be	17. Father's Name (First, Middle, La					18. Mother's Nam			i <i>uma</i> me)	
<u>X</u>	2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "naturel", or Itel aumatic event. It Medical Experies	၉	Peter P. Koe						sa Bya			
Mar	l 2 sh and r is m	n a	19a. Informant's Name/Relationship Paul Koermer					and Number or Rui				
a)	s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28a-f show other traumatic event. If a Marical Exaction I mail be recitied at		20a. Method of Disposition	/ brothe			ICOATIT	chorn Ro	ad Bal		ore MD ation - City or	
و	in it of the series or of		1 XBurial 2 Cremation 3		Hol	etery, crem LVH1	atory or other place IICemet	erv 11/			imore	
аппо	it. Partmen		<ul> <li>4 □ Donation 5 □ Other (Special Signature of Funeral Service Lie</li> </ul>				Name and Addres	an of Facility				
n n	permit. Pages 1 and Department of Heall Importent: If item 2 any injury or other once.		Tel MI	7-00	011	22.		C	_	_		omeofEssex
	F we		23a. Part1. Enter the disease, or o	mplications that caused t	the death.	Do not ente		ace Ave			e MD	Approximate
			shock, or heart failure. Listor Immediate Cause (Final	nly one cause on each line	ə. <b>\</b>		NOPF					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a			11011	1   1   1				
	Examiner			AA	Δ	00 017.						
1	- 一卷	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequen	ce or):						
X	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c.								
Š	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a	consequen	ce of):						
Q / Q	cate b physic the bu	dicai	*	d							_	
Ď X	certific nding p	0	IF FEMALE:	22a If you gutterman	4 222222							
X D D	ath	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at ti	Fetal de	ath 3 🗌	Ectopic pregnancy Other (specify)	,		23	3d. Date of del Month	livery Day Year
j	the de by the	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	ine or deati	, ,	Other (specify)					
ŗ	ires that the de signed by the a I be detached f	by Physician/M	Part II. Other significant condition	s contributing to death but	t not resultin	ng in the un	derlying cause give	en in Part I.	23e. Did to	obacco use	e contribute to	the cause of death?
cords	requires that een signed b hould be deta	p p							1 🗆 1	res 2□	No 3□Pr	robably 4 Unknown
	S 0 0	Completed							24a. Was	an	24b. Were at	utopsy findings available
T T	The law cate has b page 2 sl	E								rmed?	prior to death? 1 ☐ Yes	utopsy findings available completion of cause of
VII		a)	25. Was case referred to edical					26. Place of Deal		ne)	1 1 105	2 1 16
	S S	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	t 2 ER	/Outpatient	3□ DOA Othe	00	ome 5 Resid		☐Other (Spe	cify)
101	ng Ph ter th		27. Manne of Death  Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28	b. Time of Injury	28c. Injun Work	y at k?	28d. Describe h	now injury	occurred	
ğ	ttendir death. ctor: Af y the fu	atic	2 ☐ Accident investiga	tion				Yes 2 □ No				
DIVISION	r Att ter de irect	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ry · At home (Specify)	, farm, stre	et, factory, office		28f. Location (S City or Tox	Street and vn, State)	Number or Ru	ural Route Number,
2	urs af urs af grei D			1								
	Hosp 24 ho Fune Fune	Medical	29a. Certifier 4 Certifying (Check only 2 Medical Ex	Physician: To the best of caminer: On the basis of e	examination	dge, death and/or inv	occurred at the time estigation, in my of	ne, date and place, pinion, death occur	and due to the or red at the time, or	cause(s) a date and p	nd manner as place, and due	s stated. to the cause(s)
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.	Me	29b. Signature and title of certifier	and mailings state			29c. License	e number		29d. Date	signed (Monti	h, Day, Year)
	- > + ō		Man M				D.	T777	7	in	121	02
			30. Name and address of person w	no competed cause of de	ath (Item 23	la) (Type, f	Print)	1 1		10	1311	V)
	Ψ		Abronder	Bhana	1 0	1-1	Nanho.	A 169	Il H	wel	alkn	1021225
á	Sta		31. Date filed (Month, Day, Year)	32. Registrar	Signature	· A	M. D					
	Registr	ar	NOV 0 1 20	105	Ast &	A STATE OF THE STA	Alas Programme and the second					

			For Unpend Item State Registrar		invland / Dep Per mer Ce	rtificate of	Death		3	35191
	Physici	an	Decedent's Name (First, Middle, L	,	77	المالم مراسم		2. Date of Deat	29, 2005	3. Time of Death
	/Medic	al	James	F.	.KC	sinski	1 (5 )			6:35 P M
	Examir	er	4a. Facility Name (If not institution, g 1819 West Avenue			Dunda1k	or Location of Death		4c. County of Death Baltimore	
3	Funeral Director		5. Social Security Number 215–90–3281  Usual Residence of Decedent	Sex 7. Age	(In yrs. last birthday) 43 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, September	<sup>Y</sup> 9. Birth Con 29, 1962	nplace (State or Foreign unito) MD •
	land ow		10a. State 10b. County		10c. City, Town or Lo	ocation				10d, fnside City Limits
	with the Maryland is or 28e-f show	Funeral Director	MD. Baltin	nore	Dundall					1 Yes 2 No
	with ti	급	10e. Street and Number			10f. Zip Code		11	0g. Citizen of What Cor	untry?
	death w	era	1245 48th Street	12. Was Decedent E	ver in IIS 13	21222		onity Von er Ne	USA 14. Race - Amer	ion fodian
40	ter dea	Į,	1 Never Married 2 Married	Armed Forces?		If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, White	
Maryland 21215-0036	72 hours after death with "natural", or Items 23a or Idical Examinat In	by	3 ☐ Widowed 4 🎇 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify: Whi	te
215-(	within 72 h ene. than "nati	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)		(Give	dent's Usuaf Occup kind of work done DO NOT use retire	during most of work	sing	16b. Kind of Business/I	ndustry
21	filed within I Hygiene. other then	E O	11 years	College (1-40) 3-		Laborer			Constructi	on
b	be filed tal Hygi d other	ВеС	17. Father's Name (First, Middle, La	st)			18. Mother's Nam	e (First, Middle, M	Maiden Surname)	
/ai	wild b Ments prked	<b>To</b>	John Kosinski				Bernadin	e Pawelo	zyk	
Man	iges 1 and 2 should be filed within it of Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, the Me		19a. Informant's Name/Relationship						City or Town, State, Z	ip Code)
	of Health item 27 l	-	Mary Kufera  20a. Method of Disposition	ex-wife			Avenue, D		10. 21222 20c. Location - City or 1	Town State
Baltimore,	Pages nent of ant: ff it		1 ☐ Buriaf 2 【XCremation 3 4 ☐ Donation 5 ☐ Other (Spec	☐Removal from State city)	20b. Place of Dispo cemetery, crea Bayview (			TOUR	altimore C	
Balt	permit. Page Department of Importent: if eny injury or once.		21. Signature of Funeral Service Lic	ensee)	00, 2	Name and Addre Onnelly	Funeral H	lome Of D	undalk, P.	A.
			23a. Part1. Enter the disease or co shock, or heart failure. List on	mplications that caused	the seath. Do not ent	rer the mode of dyi	ers Point ng, such as cardiac	or respiratory arre	undalk, MD.	Approximate
The state of the s	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a Methadon	e Intoxica consequence of):					Interval Between Onset and Death
	Examiner	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):					
	ecuted and transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	consequence of):					
3760,	ate be execut hysician and he burial-tran	cal		d	consequence or).					
x 68	entific ling pl	Med	IF FEMALE:		,					
.O. Box	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	<i>'</i>		23d. Date of deliv Month	rery Day Year
<b>Q</b>	w requires that been signed b should be deta	ě	Part If. Other significant conditions	contributing to death but	t not resulting in the u	nderlying cause giv	ren in Part I.		acco use contribute to	J.
Records,	w required should should	ete						24a. Was an		opsy findings available
al Re		Completed						autopsy	prior to co	ompletion of cause of
Vital	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		oth		h (Check only one	·	
of	Phys r this ral dii	2	XXYes 2 No 27. Manner of Death	1 Inpatien		I JUDA	4 LI Nursing Ho	me 5 Resider	nce 6 Other (Speci	
on	ding th. Afte	ļ.	1 □Natural 5 □ Pending 2 □ Accident • investigati	on Found of	Found	Wor	k? Yes 2.¶∑No	200. 00001100 1101	w injury occurred	unk
Division	Attending ir death. ector: After by the fune	flca	3 ☐ Suicide 6 Could not	be 28e. Place of Injur	y - At home, farm, str			28f. Location (Str.	eet and Number or Run	al Route Number.
Ö	s after	Certification:	4 Homicide determine	House	(Specify)			Dundalk	eet and Number or Bur State) 1819 We	st Ave.
	To the Hospitel or Attenc within 24 hours after deatt To the Funeral Director: completely filled in by the i	edical (	(Check only Z V Medical Ex	Physician: To the best of	examination and/or in	n occurred at the tir vestigation, in my o	me, date and place, pinion, death occurr	and due to the car	use(s) and manner as	stated.
	thin 2 the mplei	Med	29b. Signature and title of certifier	and manner stat	ed.	29c. Licens			d. Date signed (Month,	
	¥ ₹ 8		Pots (	diam is	Tollo	O.C.M			ctober 30,	
		1	30. Name and address of person who	o completed cause of de	ath (ftem 23a) (Type,	Print) Penn Str	eet, Balt	imore. M	arvland 21	L201
	1.00		21 Data filed (Month Car Vand	1011(4) - 12	- In					
, b 😼	Sta	ta	<ol> <li>Date filed (Month, Day, Year)</li> </ol>	32. Registrar	's Signature					

			1 - For State Registrar	State of M	larylar	nd / Depa <i>Cei</i>	artmer <i>rtificat</i>	nt of Heal <i>te of Dea</i>	ith and M a <i>th</i>		giene Reg. No.	005	35192	
	Physici	an	1. Decedent's Name (First, Middle,	Last)				J. 200		2. Date of De	ath Day	Year	3. Time of Death	_
	/Medic Examin	al	Ruth R. King  4a. Facility Name (If not institution,	give street and number	-)		4b. City.	Town, or Loca	ation of Death	OCTOBE		9 2005 County of Death		
	Examin	er	SAINT AGNE		7		BA	UTIM	-			N/A		
<b>€</b> 1	Funeral Director	ě	214-01-5425	6. Sex 7. A 1 ☐ M 2 ☐ X F	ge (In yrs. 95	. last birthday) Yrs.	If Unde Months		nder 24 Hrs. urs Min.	8. Date of Bir (Month, Da March 2,	<sup>y</sup> 1910	9. Birth Con F	nplace (State or Foreign untry) Orida	7
	yland sow		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ity, Town or Lo	cation						10d. Inside City Limits	_
	e Mar	Director	Maryland Balti	more		Baltimor	'e						1 ☐ Yes 2 No	
	with the a or 21		10e. Street and Number 709 Maiden Choice La	ne RGS 319			10f. Zip	Code			•	en of What Co	untry?	
	death ms 23	Funerai	11. Marital Status	12. Was Deceden	t Ever in L	J.S. 13.			ic Origin? (Spe	ecify Yes or No Rican, etc.)		JSA 4. Race - Amer		_
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-1 show or other traumatic event, the Medical Examinar must be notified at	<u>م</u>	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	Armed Forces  1 Yes 2  If Yes, Give  Year or Dates	] No		fYes, spe 1 ☐ Yes		ecify:	Hican, etc.)		Black, White Specify: Whi		
5-0	"natu	ietec	15. Decedent' (Specify only highest	Education grade completed)		(Give	kind of wo	al Occupation ork done during ise retired)	most of work	ing	16b. Kin	d of Business/I	ndustry	
212	d withing giene.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		Teller				Ba	nk		
nd	be filed ital Hygirid other event, I	Be	17. Father's Name (First, Middle, L	ast)				i		(First, Middle,				
ryla	2 should be and Mental is marked aumatic ev	ဥ	George Z. Roland  19a. Informant's Name/Relationsh	in (Type Print)		10h Mailir	a Addros		Mamie Sp	icer al Route Numbe	City of	Town State 7	in Cordo)	_
	and 2 s fealth an m 27 is: her traus		Joan Howard/Niece	p (1990, 11111)		1		her Blvd			-	Marylan		
Baltimore,	permit. Pages 1 an Department of Heal Important: if item 2 any injury or other once.		20a. Method of Disposition  1 Durial 2 Cremation 4 Donation 5 Other (Sp	ecify)	Dri	Place of Dispo cemetery, crem uid Ridge	sition (Na	me of other place)		Date	20c. Loc	ation - City or 1 imore Mar	own, State	
Balt	permit. Departnimports any inju		21. Signature of Funeral Service L	Censee Christina	L. H	ilton   22 5.	Name ar Sopard 305 Ha	nd Address of F J. Ruck rford Roo		imore Mar	vland	21214	-	
意味	Physician /Medical Examiner		23a. Part1. Enter the disease, or a shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	nly one cause on each	Ime.	th. Do not ent				or respiratory ar	rest,		Approximate Interval Between Onset and Death 2 DAYS	
68760,	ificate be executed g physician and as the burial-transit	edicai Examiner	Sequentially list conditions, if any, beauing to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a:										
P.O. Box 6	death certif e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	al death 3 [	Ectopic p				23	3d. Date of deliving Month	∕ery Day Year	9
	requires that the heen signed by th hould be detache	ğ	Part II. Other significant condition	s contributing to death	but not res	sulting in the ur	nderlying o	cause given in f	Part I.	23e. Did to		_,	the cause of death? bably 4 Unknown	
Division of Vital Records,	The farate has	Completed								24a. Was autop perfo	sy	24b. Were aut prior to co death? 1 \( \subseteq \text{Yes}	opsy findings available ompletion of cause of	
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Other		Check only o	пе)			
on of	ding h. After fune	tion: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigs	28a. Date of Inj (Month, D		ER/Outpatien 28b. Time of Injury		OA Other: 4[ 28c. Injury at Work? 1  Yes		ne 5 🗌 Resid 28d. Describe h			fy)	_
Divisi	al or Attending s after death. Il Director: After id in by the fune	Sertification:	3 Suicide 6 Could not determine	ot be 290 Place of Ir	njury - At h	ome, farm, str fy)	eet, factor	y, office	:	28f. Location (S City or Tou	Street and m, State)	Number or Rur	al Route Number,	
	To the Hospital or Atteni within 24 hours after deatl To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one) Certifying	Physician: To the bes xaminer: On the basis of and manner s	of examina	owledge, death ation and/or inv	occurred restigation	at the time, da i, in my opinion	te and place, a	and due to the ded at the time,	cause(s) a date and p	ind manner as solace, and due	stated. to the cause(s)	
	To the within 2 To the complet	×	. 29b. Signature and title of certifier	2				c. License num				signed (Month,		
6	N		30 Name and address of norm	WW.	donth (b-	m 22a) (Time	Deint)	14385	205	123 (	ICTO	BEK S	19 2005	4
K	Sta	te	30. Name and address of pers in w MARY SUMM 31. Date filed (Month, Day, Year)	THEIS	1000 Trar's Signa	) CATT			UE	BALTI	mol	le in	29 2005 ID 21229	
, a	Registr	1.050	NOV 0 1	2005	120	1. A	Made	P						

RUTH KING

		1	1- For State of Maryland / Department of Health and M Certificate of Death		iene og. No. 005	35193
	Physici /Medio		1. Decedent's Name (First, Middle, Last) RAYMOND VERNON KURSCH SR.	2. Date of Death Month OCtober	Day Year	3. Time of Death 18:33 PM
	Examin Funeral	CI	4a. Facility Name (If not institution, give street and number)  HARBOR HOSPITAL CENTER  4b. City, Town, or Location of Death  BALTIMOR  5. Social Security Number  6. Sex 1 Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) Coul	place (State or Foreign
	Director		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	OCT 10		RYLAND  Od. Inside City Limits
	with the Ma s or 28e-f s	Director	MD A.A. GLEN BURNIE  10e. Street and Number  10f. Zip Code	10	0g. Citizen of What Cou	1 _Yes 2 No
980	72 hours after death with the Maryland "naturel", or Items 23a or 28a-f show idisal Examination and be confilled at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married   Married  1 Never Married 2 Married 2 Married  1 Never Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
21215-0036	within ene. than "	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  ELECTRICIAN	ing	16b. Kind of Business/In MARY LAND ORYDOCK + SI	dustry
land	nould be filed if Mental Hygi narked other natic event, I	To Be C	17. Father's Name (First, Middle, Last)  GEORGE  KURSCH  AG	e (First, Middle, N	Maiden Sumame)	PYLE
altimore, Mary	Pages 1 and 2 sho ent of Health and nt: If Item 27 is m ry or other treum			ATONS	20c. Location - City or To	21228 own, State
Balti	permit. F Departm Importer any injur		21. Signature of Funeral Service Licensee  22. Name and Address of Facility GOI  23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure List only one cause on each line.	NCE FUI Y BALT	NERAL SER TO MD 2	VICE, P.A. 1225 Approximate Interval Between
8760,	/Medical Examiner und principle prin	licai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and the sequence of the sequenc	•		days days
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of deliv Month	ery Day Year
ords, P	w requires that been signed b should be deta	by	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Polyneumspathy	23e. Did tob	pacco use contribute to t es 2 □ No 3 □ Prot	he cause of death?
al Records,		Completed	COPD		y prior to co death? 1 Yes	ppsy findings available mpletion of cause of 2 No
f Vital	S S	To Be	25. Was case referred to medical examiner?  1  Yes 2 No		e) ence 6 □Other (Specia	'y)
Division of	tending leath. tor: After the fune	Certification;	1 Matural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation 3 ☐ Cyclicide on the		w injury occurred reet and Number or Run	al Pauta Numbar
Divi	tel or Attences after death	Certif	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town		ar noute Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	ā	29a. Certifier (Check only one)  1. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and place, the control of the composition of the comp			
)	To the within 2 To the complet	Me	(Check only one) and manner stated.  29b. Signature and title of certifier P18 437BPC  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Ahmad Mahallati 23001 S. Hanover St. B.  31. Date filed (Month, Day, Year)  NOV 0 1 2005	$\Im A$	9d. Date signed (Month,	Day, Year)
	5x 1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Ahmad Mahallati 33001 S. Hanover St. B.	altimore	, MD, 218	225
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  NOV 0 1 2005  32 Fedistrar's Signature			

-07	7260		Please Type or Print in Bla				
			State of Maryland /	Department of Health and M	lental Hyg	iene 005	35194
		•	State Registrar	Certificate of Death		g. No.	00174
•	March 1997		Decedent's Name (First, Middle, Last)		2. Date of Deat Month		3. Time of Death
	Physicia	_	Young Ja K	im	October	Day Year 27 2005	6:30 P M
	/Medic Examin		a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		4	Dulaney Valley Road @ Timonium Ro	ad Cockeysville		Baltimor	e
** ***********************************	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	9 Birth	place (State or Foreign
3	Director		309-46-0962 1□ M 2XF 71	Yrs.	June 5,		pan
	D *		Usual Residence of Decedent         10b. County         10c. City, To	own or Location			10d. Inside City Limits
	aryla sho	5	,,,				1 ☐ Yes 2 🔯 No
	he N	Director	Maryland Baltimore  10e. Street and Number	Towson 10f. Zip Code	1	Og. Citizen of What Cou	
	a or	급			'		Titly .
	eath Ires	Funeral	1006 Timber Trail Road 11. Marital Status 12. Was Decedent Ever in U.S.	21286 13. Was Decedent of Hispanic Origin? (Sp.	ecify Yes or No-	USA 14. Race - Ameri	can Indian,
	ter d	Fun	Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	etc.
ဗ္ဗ	urs a	by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2√ No Specify:		Specify: Whi	ite
Ŏ	2 ho	ted	15. Decedent's Education (Specify only highest grade completed)	Sa. Decedent's Usual Occupation (Give kind of work done during most of work	ina	16b. Kind of Business/Ir	
2	thin 7	ple	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)		Johns Hopki	ins
21215-0036	gien gien grth	Completed	12 5+	Professor Emeritus			- Education
덜	al Hy al Hy d oth	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, M	Maiden Sumame)	
yla	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  Is marked other than "natural", or Items 23s or 28s-f show eumatic avent, the Madical Executarinal be recitified at	ဥ	Sung Wook Kang	Chung		Park	
Baltimore, Maryland	Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural; or items 23a or 28a-f show the river or other treumatic avent, the Madical Examination in all be notified at any or other treumatic avent, the Madical Examination.	1	19a. Informant's Name/Relationship (Type, Print)	9b. Mailing Address (Street and Number or Run			o Code)
2	and ealth m 27		Dr. Chung Wook Kim / Husband	1006 Timber Trail Roa			
Ore	of H if ite		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State	of Disposition (Name of Interry, crematory or other place)	Jale	20c. Location - City or T	own, State
Ē.	permit. Page Department of Important: If sny Injury or once.			Crematory 11/1/		Catonsvill	e, Maryland
all all	Depart Import Import In In		2 Fund   Service Licen	22. Name and Address of Facility Lemmon Funeral Hom	e of Dul	aney Valley	/ Inc.
	<u>v</u> ∪ = a a		Bryan W. Clary	10 W. Padonia Road	, Timoni	um, MD 210	193
			23a. Part1. Enter the disease, or complications that caused the death. I shock or heart ailure. List only one cause on each line.	o not enter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
1	Pnysician	7 W	Immediate Cause (Final disease or condition	ole Injuries			Onsot and Boath
1 15	/Medical Examiner		resulting in attitute a. Due to (or as a consequen	pe of):			
	LXammer	_	Sequentially list conditions, b.				
1	sit ad	Examiner	Sequentially list conditions, if any leading 12 mmadrate cause. Enter Underlying Cause (Disease or injury	ce or):			
	be executed icien and burial-transil	хап	that initiated events c. resulting in death) Last Due to (or as a consequent	ce of):			
60,	be executed sicien and burial-transit						
687	leath certificate I attending physi I for use as the t	by Physician/Medical	d				
×	the death certificate y the attending phys iched for use as the	₩	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliv	/ADV
Box	atten for u	clan	in the past 12 months?	ath 3□Ectopic pregnancy		Month	Day Year
P.O.	the the	ysi	1 ☐ Yes 2 ☐ No 9☐ Unknown				
	res that the signed by be detact	Y P	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
sp.	The law requires that ate has been signed b page 2 should be deta	D D			1 □ Y€	es 2 No 3 Pro	bably 4 Unknown
2	w require been si should	Completed			24a. Was a	n 24b. Were aut	opsy findings available
Re	The lav	Ę			autops perforr	y prior to co ned? death?	ompletion of cause of
ā		Ö	25. Was case referred to medical	26. Place of Deat			2□ No
Division of Vital Records,		00	examiner? Hospital:			ence 6x <b>30</b> ther( <i>Speci</i>	M Scana
of	Phya ar this aral di	): To	27. Manner of Death 28a. Date of Injury 28	b. Time of 28c. Injury at	28d. Describe ho	w injury occurred	
o	th. : Afte	ig ig	1 □Natural 5 □ Pending (Month, Day Year) 2 📉 Accident investigation (D) 3 1 0 5	Injury Work?  □ Yes 2 No	Drive	accident	or vehicle
/isi	of or Attending after death. Director: After din by the fune	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home	, farm, street, factory, office	28f. Location (St	reet and Number or Run	al Route Number, 10 1
ă	afte s afte I Dir	ert		way		1, State) Dulani	OCKEYSU HELLD
	Hospitel 24 hours a Funeral C		Zira Gertifier 1 Certifying Physician: To the best of my knowle	dge, death oppared at the time, sale and place,	and due to the co	use(s) and manner as	stated
	To the Hospitel or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medical Examiner: On the basis of examination and manner stated.	and/or investigation, in my opinion, death occur	ed at the time, d	ate and place, and due	o nie cause(s)
	To the transfer of the transfe	Σ	29b. Signature and title of certifier	29c. License number OCME	2	9d. Date signed (Month)	Day, Year)
	1		(and Hallan	wa		October 28	
	15		30. Name and address of person who completed cause of death (Item 23	a) (Type, Print) 111 Penn Stree	et Balt	imore, Mary	
	1-		CURUCH MIM	21			
2		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Spark!			
	Regist	rar	NOV 0 1 2005	- /			

,			- StateUnpend Item					Health an			2005	5 35195	
0	依	-4-	Decedent's Name (First, Middle	, Last)						ate of Death		3. Time of Death	
	Physici		Sharon Marie Ki	tzmiller						tober	25, 200	05 11:45 A <sup>M</sup>	
	/Medic		4a. Facility Name (If not institution		umber)		4b. City, Town	, or Location of D			4c. County of		
The same	200	28.	216 Shaw Stree	t. Apartn	ment 4		Fre	stburg			Alleg	gany	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Day		Hrs. 8. D	ate of Birth Month, Day, Y	(ear)	Birthplace (State or Foreign Country)	
T B	Director		212-90-0362	1 □ M 2 🔀 F	41	Yrs.	monus buy		1	1-19-1	-1963 MD		
	DC 💌		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits	
	sho	5	,	1								1 ☐ Yes 2 🖾 No	
	the Maryland 28e-f show	Director	MD Alleg	hany	Fi	rostbur	10f. Zip Code			100	g. Citizen of Wh	aat Country?	
	a or			L A	<i>l</i> .					100		iat ooanii).	
	ms 23a or	eral	216 Shaw Stree		cedent Ever in U	J.S. 13.	215 Was Decedent of	f Hispanic Origin	? (Specify	es or No-	U.S.A.	- American Indian,	
Maryland 21215-0036	or its	by Funeral	1 □ Never Married 2 Marri 3 □ Widowed 4 □ Divorced	Armed F	Forces? 2⊠No Bive		f Yes, specify C 1 ☐ Yes 2🔀 N	uban, Mexican, P	uerto Ricar	i, etc.)		White, etc. White	
9	72 hours	ted	15. Decedent		41	16a. Dece	dent's Usual Occ	cupation ne during most of	f working	16	Bb. Kind of Busi	iness/Industry	
215	C 30	Completed	(Specify only highes Elementary/Secondary (0-12)	- T	(1-4or 5+)	life.	DO NOT use ret	red)	WORKING				
21	if Hygiene. other then	Ю	12	3		Medic	al Tran	scriptio	nist		Medical	1	
b	be filed ntal Hygi od other event, L	Be	17. Father's Name (First, Middle,	Last)							iden Sumame,	)	
<u>a</u>	uld b Ments wrked	10	Raymond Grab					Rosali	le Kro	tky			
a	and Is ma		19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address (Stre	et and Number o	or Rural Rou	ite Number, (	City or Town, S	tate, Zip Code)	
	and 2 salth n 27		Rosalie Grab /	Mother				c Cam R					
ore	of He		20a. Method of Disposition 1 □ Burial 2 【 Cremation	3 □Removal from		Place of Dispo cemetery, crei	sition (Name of natory or other p	place)	Date	20	c. Location - C	ity or Town, State	
Ĕ	Pag nent ant: I	-	4 Donation 5 Other (S		Cł	nesapea	ke Crem	ation 10	)-31 <b>-</b> 2	005 S	Stevensy	ville, MD	
Baltimore,	permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other treumatic even once.		21. Signatule of the Stryic	Licensee	<b>₹</b> \			dress of Facility  Ave SW;	_			Home PA 21061	
	Physician /Medical		23a. Pan1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on a. <b>Hype</b>	each line. rtensive	e Heart			rdiac or res	piratory arres	it,	Approximate Interval Between Onset and Death	
	Examiner			Due to	o (or as a consec	quence of):							
族		<u>-</u>	Sequentially list conditions,	b. Due to	o (or as a consec	guence of):							
	nsit	r L	cause. Enter Underlying Cause (Disease or injury	•									
o,	cate be executed physicien and the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to	o (or as a consec	quence of):							
68760,	tificate be ig physici as the bu	edical		d							1		
P.O. Box	Attanding Physicien: The law requires that the death certific death. sctor: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ★Unknown	1 ☐ Live	outcome of pregn b birth 2 Peti gnant at time of a known	al death 3[	□Ectopic pregna □ Other (specify,				23d. Date Monti	,	
Division of Vital Records, P	quires that n signed b ald be deta	ed by PI	Part II. Other significant condition  End Stage Renal			sulting in the u	nderlying cause	given in Part I.				oute to the cause of death?  B Probably 4 Unknown	
00	aw require as been si 2 should b	olete								24a. Was an	24b. W	ere autopsy findings available	
Re	The lay ate has bage 2	mo								autopsy performe X Yes 2	ed? de	ior to completion of cause of eath? ☑Yes 2☐ No	
ia	sicien: The certificate har rector, page	BeC	25. Was case referred to medica					26. Place of	Death (Ch	eck only one			
<b>\</b>	lysic lis ce direc	To	examiner? 1 <b>∑</b> Yes 2□No	Hospital:	Inpatient 2	] ER/Outpatie	nt 3 DOA	Other: 4 🗆 Nursi	ing Home	5 🗌 Residen	ce 6 XOther	(Specify) at scene	
0	ding Ph h. After th funeral	ü	27. Manner of Death 1 A Natural 5 □ Pendin	28a. Dat (Mo	e of Injury onth, Day Year)	28b. Time o	f 28c. lr	njury at Vork?	28d.	Describe how	injury occurred	d	
Ö	death. ctor: Al	atic	2 ☐ Accident investi	gation			M 1	☐Yes 2☐No	)				
Νį	or Atta	Certification:	3 Suicide 6 Could 4 Homicide determ	ined 286. Pla	ce of Injury - At h Iding, etc. <i>(Spec</i>		reet, factory, offi	ce	28f. L	ocation (Stre City or Town,	et and Number State)	r or Rural Route Number,	
	Itel of Irs af rel D rel D led ir												
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29a. Certifier 1 Certifyir (Check only one) 1 Medical		he best of my kn basis of examin anner stated.	owledge, deal ation and/or in	h occurred at the vestigation, in m	e time, date and p ly opinion, death	place, and o occurred at	the time, dat	ise(s) and mani e and place, ar	ner as stated. nd due to the cause(s)	
	within To th	ž	29b. Signature and title of certific	(	^			ense number		290	d. Date signed	(Month, Day, Year)	
			Matt	lumica	-100C	OR NAV	0	CME		00	tober 2	26, 2005	
	7		30. Name and address of person	who completed ca	use of death (Ite	m 23a) (Туре,	Print) 111	Penn St	reet	Balti	more, M	Maryland 21201	
1			TATRICIA /	Aranica	- HILA	Ku	D						
	St Regist	ate rar	31. Date filed (Month, Day, Year)	2005	Registrar's Sign	nature do	well .						

1			For State Registrar		partment of Health and ertificate of Death		<b>2</b> 005 35196
	Physici /Medic	_	1. Decedent's Name (First, Middle, Last)  Dominic Kir	4		2. Date of Death Month October	Day Year 25 2005 0231 A M
	Examin	er	4a. Facility Name (If not institution, give Johns Hopkins Ho	spital	4b. City, Town, or Location of Dea		4c. County of Death
	Funeral Director		5. Social Security Number  6. Security Number  15  Usual Residence of Decedent	7. Age (In yrs. last birthda M 2□ F 2D Yrs	Months Days Hours Min		(ear) 9. Birthplace (State or Foreign County) Mary (and
	death with the Maryland ma 23s or 28s-f ehow rmat be notified at	ctor	10a. State 10b. County  Maryland N/A	10c. City, Town or	Battimore		10d. Inside Øity Limits 1 ØYes 2 □ No
	23a or 28	Funeral Director	1925 E. 30th	54.	10f. Zip Code 21218		g. Citizen of What Country?
5-0036	or Ite	by	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (     If Yes, specify Cuban, Mexican, Pue     □ Yes 2 □ No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
21215-0	within 72 ho iene. r than "natur tre Medicel I	Completed	15. Decedent's Edu (Specify only highest grad	e completed) (G	cedent's Usual Occupation ive kind of work done during most of wo be DO NOT use retired) UNEMPOYED	orking 16	8b. Kind at Business/Industry
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, Ita Ms	To Be C	17. Father's Name (First, Middle, Last)  Cad Brown		18. Mother's Na Maril	me (First, Middle, Ma	iden Sumame)
	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any Injury or other traumatic event, It a Medical Exagnes.		19a, Informant's Name/Relationship (Ty Marium Kimp) 20a, Method of Disposition	nother 197	ailing Address (Street and Number of F 25 E, 30 + S sposition (Name of trematory or other place)	: BAHIA	City or Town, State, Zip Code)  Whe Mary and 24216  Ic. Location - City or Town, State
altimore,			1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens	iemoval from State M. Zie	22. Name and Address of Facility	5705 L	and solowne Maryand
8	9 9 E E G		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death. Do not no cause on each line.	35/2 Firedexic enter the mode of dying, such as cardia	Ave Ba	Himory Manyland (Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	that wounds		Onset and Death
8760,	be executed cian and ourial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):			
Box 6	death certifi e attending id tor use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \) 9 \( \text{Unknown} \)		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
rds, P.O.	Se US	d by Ph	Part II. Other significant conditions con	ntributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
l Reco	elaw hasb	Completed				24a. Was an autopsy performe 1 X Yes 2	24b. Were autopsy findings available prior to completion of cause of death?
Vita	ician: certitic rector,	Be	25. Was case referred to medical examiner? 1X Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 🖫 ER/Outpa	Othor	eath (Check only one)	
Division of Vital Records,	uttending Physical death.	atlon; To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ② ER/Outpa  28a. Date of Injury (Month, Day Year)  Found 10-25-05 Found 3	e of A 28c. Injury at Work?	28d. Describe how	
Divis	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: Atter completely filled in by the tuner	Certification;	3 Suicide 6 Could not be determined		eet	Ave Ba	et and Number or Aural Route Number, State) 1800 blk Guiford Itimore mD
	Hosp 124 hou Fune letely fi	Medical	29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exami	sician: To the best of my knowledge, do ner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occ	e, and due to the cau curred at the time, date	se(s) and manner as stated.  a and place, and due to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier		29c. License number OCME		I. Date signed (Month, Day, Year)
•			30. Name and address of person who co	t m Dompleted cause of death (Item 23a) (Tyl	pe, Print) 111 Penn Str	eet Balti	October, 25, 2005 more, Maryland 21201
	\		LING LI	mid			
	Sta Registi		31. Date filed (Month, Day, Year) NOV 0 1 2005	3. Registrar's Signature	and a		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#101, 19a-b, perFh, 8849 11-1-05 TT

State of Maryland / Department of Health and Mental Hygiene 055 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** .30am Karshmer 29th 2005 )ctobe /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner STELLA MARIS HOSPICE TIMONIUM BALTIMORE 8. Date of Birth (Month, Day, Year) JUL . 20, 1941 If Under 1 Year Months Days If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 🔽 F 64 Director 250-70-8870 NY Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatih and Mental Hygiene. ant: If Item 27 Ia marked other than "natural", or Items 23a or 28a-f show 10b. County 10c, City, Town or Location 10d. Inside City Limits 10a. State Item 27 Ia marked other than "natural", or Items 23a or 28a-4 show other traumatic avant, the Medical Evantral must be notified at 1 ☐ Yes 2 ☑ No Director BALTIMORE BALTIMORE 21209 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 2808 QUARRY HEIGHTS WAY USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be **ROSEMAN** CAPLAN RAYMOND SHIRLEY 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zia Coch 19a. Informant's Name (Pelation chip (Type, Print)

NORMAN KARSHNER / HUS 2808 QUARRY HEIGHTS WAY - BALTIMORE, MD HUSBAND 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 4 □ Donation 5 □ Other (Specify) BALTIMORE HEBREW CEM:10/31/2005 REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee Tola <u> 18900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Me **Physician** MONTH ta 5 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Directo for as a nonsequence offi-Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medlcal use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 2 Yes 2 No Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 № No 24a. Was an has autopsy certificate 1 ☐ Yes 2⊠ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: P 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 5 Pending investigation 1 Natural 2 No 2 🖺 Accident Director: filled in by the 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M -mestine

Registrar

State

DU

Koad

2300

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

NOV 0 1 2005

MD

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 35198 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2005 October **Physician** 6:00 am Little Contee /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Rosedale 7916 Shirley Avenue if Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 21 19 Birthplace (State or Foreign Country) 6 Sex 5. Social Security Number **Funeral** 1 № M 2 🗆 F 66 219-26-9183 May Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r then "natural", or Items 23a or 28e-f ehow the Medical Examinar must be notified at 1 Yes 2 No Rosedale Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21237 **USA** 7916 Shirley Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "natural", or item any injury or other traumatic event, the Medical Examinate once. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **Black** Jane Myrtle Little Wilev Blaine 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7916 Shirley Avenue, Rosedale, MD 21237 Nancy Little - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory Inc 10/31/2005 Beltsville, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses <sup>22</sup> CAFA, Stephen D. Lohrmann, PA 8717 Green Fastures Drive, Towson, MD M00986 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final disease or condition resulting in death) AS **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐No for 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 99 1 ☐ Yes 2 ☐ No 3 Probably 4 ∰Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page certificate 1 Yes 2 No 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 25 No 1 Inpatient 3 DOA P 2 ER/Outpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 5 Pending Natural 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funerel Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗀 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2005 1 Registrar

			1 - For State Registrar	State of Maryland / D	epartment of Health Certificate of Deat	n and Mer th	ntal Hygien		35199
	Physici	an	Decedent's Name (First, Middle, Last)					ay Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s	street and number)	4b. City, Town, or Locatio		-	c. County of Deal	h
			3207 Texas	Avenue	day) If Under 1 Year   If Und	e der 24 Hrs.   8		BALTIM	ORE
	Funeral Director		5. Social Security Number 6. Security Number 15.	In other	Months Days Hours	s Min.	Date of Birth (Month, Day, Year		hplace (State or Foreign untry) GRU/Cinc
	ס		Usual Residence of Decedent  10a, State 10b, County	10c. City, Town	or Location		9 777	75 77 70	10d. Inside City Limits
	Maryia	tor	MD Baltima	0 01					1 □ Yes 254No
	or 28s	Director	10e. Sireel and Number		10f. Zip Code	,	10g. C	itizen of What Cor	untry?
	eath w	Funerai	3207 1eXC5 1	Venue 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic (	Origin? (Specify	Yes or No-	14. Race - Amer	rican Indian.
9	after d or Iten	/Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 275 No If Yes, Give	If Yes, specify Cuban, Mexic	can, Puerto Ric	an, etc.)	Black, White Specify: 1	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene important: if item 27 is marked other than "naturei", or items 23a or 28a-f show any figury or other traumatic event, the Medical Erath for must be notified at once.	ed by	3 Widowed 4 □ Divorced  15. Decedent's Edu	Year or Dates:	Decedent's Usual Occupation		16b	Kind of Business/I	)hite
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2	Hygien Hygien ther th	Con	17. Father's Name (First, Middle, Last)	Ua	Ues 18 Mar	other's Name /F	irst, Middle, Maide	tzler 19	5
au	ould be f Mental I Marked of	To Be	12.12	SCTORGS	$\sim$	Volví	Ham	1000	
lary	2 should to and Ment is marked raumatic of		19a. Informant's Name/Relationship (Ty	pe, Print) 19b. i	Mailing Address (Street and Num	mber or Rulal R			1
	1 and Health tem 27		20a. Method of Disposition	Thomas clausinher 3	Disposition (Name of crematory or other place)	lace A	Hoingdon,	ocation - lity or 1	dalcog Town, State
altimore,	Pages nent of I int: if its ury or o		↑ Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	elliuvai itutii State   1 1	my Cenelou	NOV 2	2005 Per	ekville 1	Maryland
Balti	permit. Departn imports any inju		21. Sign Jure Funeral Service License	- Land. I.	22. Name and Address of Flo	cility Evan	5, Chape	1 OF ME	emeries
	40260		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	carlohs that caused the or ath. Do no	18800 Halford It enter the mode of dying, such	as cardiac or re	Packuill espiratory arrest,	e MYKRU	Approximate
3	Enysician :		shock, or heart failure. List only or Immediate Cause (Final disease or condition	ne/cause on each line.	otic Don	1000		2	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of	):				(1014 0)
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Linease or Ajury	Due to (or as a consequence of	):				
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8760,	e be ex sician e burial	dicai E		Due to (or as a consequence of	<i>,</i> .				
9	ntificate ng physi s as the f	Medic	IF FEMALE:						
Вох	eath certific attending p	clan/l	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deliver Month	very Day Year
P. 0.	that the de ned by the a detached f	Physician/Me	1 ☐ Yes 2 <b>D</b> No 9 ☐ Unknown	9☐ Unknown					
Records, F	sigr sigr	by	Part II. Other significant conditions cor	Ilributing to death but not resulting in	he underlying cause given in Par	nt I.		1	the cause of death?
Seco.	ne law requ nas been ge 2 shouli	Completed			-		24a. Was an autopsy	prior to co	topsy lindings available completion of cause of
Viital		0	25. Was case referred to medical		26 Pla	ace of Death (C	performed?  1 Yes 2 No	o 1 ☐ Yes	2 No
	y S	ToB	examiner?	lospital: 1   Inpatient 2   ER/Outp	Other		5 desidence	6 □Other (Spec	eify)
ouo	ding Pl h. After tl funera		27. Manner of Death  → Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tii	me of 28c. Injury at work?  M 1 ☐ Yes 2		. Describe how inju	iry occurred	
Division of	or Attending ter death. irector: After in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f.	Location (Street a. City or Town, Stat	nd Number or Rui e)	ral Route Number,
Ω	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier Certifying Phys	sician: To the best of my knowledge,	death occurred at the time, date	and place, and	due to the cause(s	a) and manner as	stated.
	the Hohin 24 the Fu	Medicai	one)	ner: On the basis of examination and and manner staled.					
)	To To	-	29b. Signature and title of Certifier	Wars in	29c License numbe	779	290. Da	ale signed (Month,	200 T
1	N		30. Name and address of person who co	mpleted cause of death (Item 23a) (T	ype, Print	- DA	5-000	7 01/	71764
1	O Sta	te.	31. Date filed (Month, Day, Year)	32. Sigistrar's Signature —	LAUIUS X	1 18	n mil	MM1 5	2/20/
	Registr			105 Show St	Speciel	•			

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	Physicia		1. Decedent's Name (First, Middle, Last)	Lipse	romb		2. Date of Dear	th Day Yea	
	/Medic Examin	er	4a. Facility Name (If not institution, give street and number Baltimore VA Medical	"Center	4b. City, Town, or	Location of Death	4c. County of Death		
	Funeral Director			Age (In yrs. last birthday) 79 Yrs.	Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) 08 28	9. E	Birthplace (State or Foreign Country) VA
	D	-	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Le	ocation				10d. Inside City Limits
	Maryla	tor	MD NA	Baltimo	ore				1 X Yes 2 □ No
	vith the	Funeral Director	10e. Street and Number		10f. Zip Code	1015	1	0g. Citizen of What	
	ns 23e	eral	2425 Keyworth Ave	nt Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	1215 lispanic Origin? (Spe	cify Yes or No-	U • S	merican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating the matter and once.	by Fun	Amed Force:  1 □ Never Married 2 □ Married  1 ☑ Yes 2 □   ] No	If Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	Rican, etc.)		hite, etc. Black	
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Maryland 21215-0036	d be file antal Hy ced othe c event,	To Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name			
aryl	shoul and Me is mark	Ĕ	I. inwood I. inscomb  19a. Informant's Name/Relationship (Type, Print)			and Number or Rura	l Route Number	r, City or Town, State	
e, S	Health Health em 27 ther tr	1	Joyce Ragland-Sams-Ned		O Chelse osition (Name of omatory or other place			nore, Md	21215 or Town, State
mor	Pages nent of nt: If it iry or o		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	10	ematory or other place on Fores	<u> </u>	05	Owings	Mills, Md
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee	)	March F/	H West	Balti	imore, M	d 21215
			23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause or each						Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	as a consequence of):	oca				Onset and Death
f	Examiner		Sequentially list conditions, b.	1. 0	eumonic				1 DAY
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8760, 8	icate be executed physician and s the burial-transit	I Exar	that initiated events c.	as a consequence of):					
687	ificate t g physia as the b	edical	d						
Вох	that the death certificed by the attending properties as	Physician/Me		2 Fetal death 3	□Ectopic pregnancy	/		23d. Date of o	delivery Day Year
o.	the de by the a ached f	hysic	1 Yes 2 No 4 Pregnant 9 Unknown 9 Unknown		Other (specify)				
rds, P	es gu	by	Part II. Other significant conditions contributing to death  Abdomical CANCEN	t but not resulting in the t	underlying cause giv	en in Part I.			to the cause of death?  Probably 4 □Unknown
Records,	e law requir has been si je 2 should	Completed	EmphysemA				24a. Was a autops	sy prior	autopsy findings available to completion of cause of
Vital B		e Cor	25. Was case referred to medical			26. Place of Death		2 No 1 Y	es 2 No
f <i< th=""><th>S S</th><th>To B</th><th>examiner?  1 Yes 2 No Hospital: 1 Ninpa</th><th>atient 2 ER/Outpatie</th><th>ent 3 DOA</th><th>05</th><th></th><th>ence 6 🗆 Other (S</th><th>pecify)</th></i<>	S S	To B	examiner?  1 Yes 2 No Hospital: 1 Ninpa	atient 2 ER/Outpatie	ent 3 DOA	05		ence 6 🗆 Other (S	pecify)
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_	Hospita 4 hours Funeral ely fille	edical Ce	29a. Certifier (Check only one)  29a. Certifying Physician: To the best of the best only one)	of examination and/or in					
	To the within 2. To the I complet	Med	29b. Signature and title of certifier	Stated.	29c. Licens	se number	2	29d. Date signed (Mo	onth, Day, Year)
			* Feyer Shal M	1.	AUGIT	6437 515	137	october	27,2005
	1501		30. Name and address of person who completed cause of			BA. 7	TMADE	s am,	1201
	Sta Regist			Strar's Signature	- N -	UHLI	TIMONE	TILB E	1.0
	ricgist	T.I	NUV U I CUUD   COM	188 1 A.S. 6					

State of Maryland / Department of Health and Mental Hygiepe [] 5 35201 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Dorothy Elizabeth Loughrey October 26, 2005 7:55 P /Medical 4c. County of Death
Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Glen Meadows Retirement Community Glen Arm If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign
Country) **Funeral** 1□ M 2√2 F Months Days 143-01-2652 85 Director 1920 Germany Apr. 10, Usual Residence of Decedent the Maryland 10c. City, Town or Location 10h County 10a State 10d. Inside City Limits item 27 is marked other than "natural", or itema 23a or 28a-1 show other traumatic event, the Medical Exeminar must be notified at 1 ☐ Yes 2 No Glen Arm Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21057 11630 Glen Arm Road death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. OO NOT use retired) 16b. Kind of Business/Industry 2 should be filed within and Mental Hygiene.

Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Pharmaceutical Secretary 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Oscar (UNK) Kaufman Anna Barbara Merz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: if item 27 Is m any injury or other traum QDCE. P. O. Box 48, Bel Air, MD 21014 Barbara Shannon/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 10-31-2005 Towson, MD 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility.

McComas Funeral Home, P.A. (ussell 1317 Cokesbury Road, Abingdon, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gluse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mys cardia Physician /Medical to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) Examine if any, loading to immedit cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the attending physician and the for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760 99 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 menths?

1 Yes 2 No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown n signed by the Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 □Unknown 1 🗆 Yes Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 🗌 Yes 4 ☐ Nursing Home 5 Mesidence 6 ☐ Other (Specify) 0 1 Inpatient 2 ER/Outpatient 3□ DOA this funeral . Monner of Death 1 Atural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Hospital or Attending Pl
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 Funeral Director: After the Certification: 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier Two certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier th (Item 23a) (Type, Print) 30. Name and address of person who completed cause of de BATI MORE MOULDL BMe 10 6 CHARLES 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2005 NOV 0 1

Amend State of Maryland Department of Health and Mental Hygiene 2005 35202 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear **Physician** Lochridge Edward October 0122 M 2005 31 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Johns Hopkins Bayview Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
April 8, 1947 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) District **Funeral** Months 1⊠M 2□ F <del>233</del>64 1513 58 Director OF Columbia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 90cg. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA 7841 Deboy Avenue Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 X Married 1XYes 2 No Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No þ lf Yes, Give Year or Dates: Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steamfitter **HVAC** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Owens William Joseph Lochridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7841 Deboy Avenue Baltimore, Maryland 21222 Joyce E. Lochridge (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State
1 ☐ Donation 5 ☐ Other (Specify) 11/1/2005 Bayview Crematory Baltimore, Maryland 21. Signature & Funeral Service Jacensee <sup>22. Name</sup> and Address of Facility Bruzdzinski Funeral Home P.A. onn 1407 Old Eastern Avenue Essex, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Septic Shock resulting in death) /Medical Due to (or as a consequence of): **Examiner** Preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine 9 months The law requires that the death certificate be executed burial-transil Idiopathia Fibrus Pulmonary attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown ģ det signed Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 X No 3 ☐ Probably 4 ☐ Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate 1 ☐ Yes 2 XNo 1 Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 🔀 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No ٢ 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 5 Pending investigation 1 X Natural М 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number RESCOI October 31,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTORN AVOING BALTIMORE, MD 21224 TATA PERTI 32. Egistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

NOV 0

1 2005

State of Maryland / Department of Health and Mental Hygiere 15 35203 1- State Registra-Amend Item #8 Per FH G849 11 Con #105 at Hof Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Wilma Arlene Miller 10 31 2005 1:50 A /Medical 4a. Fecility Name (If not institution, give street and number) 4b. Cilv. Town, or Location of Death 4c. County of Death Examiner Wilson Health Care Center Gaithersburg Montgomery 8. Date of Birtt 7-08-1917. Birthplace (State or Foreign (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 305-24-9158 6. Sax 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 ☐ M 2 € NF 88 Yrs Director Indiana Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "netural", or items 23a or 28e-f show other treumatic event, the Medical Examinar must be notified at MD 1 ☐ Yes 2√1No Montgomery Wheaton Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2613 Elnora Street 20902 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after a and Mental Hygiene.

Is marked other than "netural, or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: white XXX Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oscar Grover Slonaker Anna Marsha Wise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 Is m any injury or other treum <u>once.</u> Peter Miller/son 13709 Loree Lane Rockville, MD 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State Chesapeake Crematory 10-31-2005 Beltsville, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Rapp Funeral & Cremation Service, 933 Gist Ave mo1358 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Respiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine burial-transit Cause (Disease or injury that initiated events failure To Thrive resulting in death) Last Due to (or as a consequence of): Box 68760 the attending physician certificate be Dementia Physiclan/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 Fetal death in the past 12 months? ţō Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed Was a autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: ANursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) • Hospitel or Attending Pl 24 hours after death. • Funerel Director: After the 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes investigation 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 124 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) To the I within 2. To the I and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10-31-2005 D35791 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Georgia Ave Ste 227 Silver Spring, MD 20902 Merlyn Vemery 9801 \$2. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 1 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie ( ) 5 35204 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 12 20 A.M Physician Ktober Jorothy T. Jocks 4a Eacility Name (If not institution, give street and number) accos /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Maris BALTIMORE Hella Under 1 Year | If Under 24 Hrs. onths | Days | Hours | Min. 8. Date of Birth (Month, Day, 7. Age (In yrs, last birthday) Yrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sax **Funeral** Months 1 M 200 F 216-24-393 BALTIMORE, MO Director Usual Residence of Deceden with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. Slate 10h County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Tes 2 No BALTIMORE BALTIMORE Be Completed by Funeral Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2345 21234 Bridge 72 hours after death 12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5 + 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marie Danashak 19a. Informant's Name/Relationship (Type, Print) ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $2 p_3 \sqrt{3}$ harles Miller 202 Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other slace, 5 Burial 2 ☐ Cremation 3 ☐ Removal from State 3/05 BALTIMORE, MD Moreland Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Litense 22. Name and Address of Frequency mo 21234-23a. Part I. Enter the diserved or corp lications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Figure 1997). SOONHARFORD RD RD Approximate Interval Between Onset and Death Immediate Cause (Fina Physician PANCREATIC CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury Use to for as a consecuence of burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the ettending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 👿 No Month Day Year 5 Other (specify) signed by the e o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ð Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed? certificate 1 ☐ Yes Vital 25. Was case referred to medical Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 10 Other (Specify) 2 1 Tes 2**▼** No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA HOSPICE o : After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 XNatural 5 Pending death. investigation 2 Accident within 24 hours after death To the Funeral Director: / completely fitted in by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 DR. TARIQ MAHMOOD 39. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 1 2005 Registrar

2005

MILLER

DOROTHY

			- State Amend Item 1 Registrar	State of Maryla .6b per FH G84	and / Dep 9 <b>11/</b> _l	artment of F	lealth and M Death	ental Hyg	ie29 05	35205
	Physici /Medic		1. Decedent's Name (First, Middle,	Paul	MICE	YCAR		2. Date of Deal	th Day Year 29 200	3. Time of Death  2 o A M
	Examin	er	4a. Facility Name (If not institution, of NENT WOR	give street and number)		4b. City, Town, o	Location of Death		4c. County of Dea	ath P
	Funeral Director		5. Social Security Number 6. 15 · 32 · 2700	Sex 7. Age (In y	rs. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	, Year) C	thplace (State or Foreign ountry)
	with the Maryland e or 28e-f show Le notified at	tor	Usual Residence of Decedent  10a. State  10b. County	FORD 10c.	City, Town or L	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the	Director	10e. Street and Number	T LITOR T	D C	10f. Zip Code		1	Og. Citizen of What C	ountry?
36	72 hours after death with the Marylan naturel', or items 23e or 28e-1 show itsal Estaninet must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1   Yes 2   No If Yes, Give Year or Dates:	1 U.S. 13.	Was Decedent of Hif Yes, specify Cuba	Dispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
21215-0036	"natur	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		(Give		during most of working	ng	16b. Kind of Business DEFENSE	*
land	al Hyg	To Be C	17. Father's Name (First, Middle, La	McGR			18. Mother's Name		Maiden Sumame)	Z
Maryland	D = 1. 3		19a. Informant's Name/Relationship		19b. Mail	ing Address (Street		I Route Number	City or Town, State,	
Baltimore,	Pages 1 an nent of Heal nnt: If item 2 ury or other		20a. Method of Disposition  1  Burial 2 Cremation 3  4 Donation 5 Other (Spe	□ Removal from State	cemetery, cre	osition (Name of or other place) MEMORIA	(a)	ate 2.005	20c. Location - City of	1
Balti	permit. Page Department Importent: II any injury o		21. Signature of Funeral Service Lie	ensee Mol22c		2. Name and Addre	ss of Facility EVA	VOS FILE	1 )	BEL A12 MD 21050
	Physician		23a. Part1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition	emplications that caused the daily one cause on each line.	eath. Do not er		•		est.	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con.	sequence of):				7	
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	sequence of):					
8760,	cate be executed physician and the burial-transit	dical Ex	resulting in death) Last	Due to (or as a cons	sequence of):					
Box 6	The law requires that the death certific. It has been signed by the attending ploage 2 should be detached for use as it.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etal death 3	□Ectopic pregnancy	/		23d. Date of de Month	livery Day Year
ds, P.0	uires that the signed by Id be detact	by	Part II. Other significant condition	•	resulting in the	underlying cause giv	en in Part I.	23e. Did tot	bacco use contribute t	o the cause of death?
Vital Records,		Completed						24a. Was a autops perforr	med? prior to death?	utopsy findings available completion of cause of
	ysiclen: Th is certificate director, pag	To Be (	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	? ☐ ER/Outpatie	ent 3 DOA Oth	26. Place of Death			ecify)
Division of	ng Ph Íter th Ineral		27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Injury (Month, Day Year		of 28c. Injur Wor	to be come to be from the first of the first blood of the company		ow injury occurred	
Divis	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could no determin		kt home, farm, s ecify)	treet, factory, office	2	28f. Location (St City or Town	treet and Number or R n, State)	ural Route Number,
	he Hospitel or in 24 hours afte he Funerel Dir pletely filled in I	edical	(Check only 2 Medical Ex	Physicien: To the best of my saminer: On the basis of examand manner stated.	knowledge, dea nination and/or i	nvestigation, in my o	pinion, death occurre	ed at the time, d	ate and place, and du	e to the cause(s)
	To the within 2. To the Complet	₹/	29b. Signature and title of certifier	n.s		29c. Licens	e number 45390		9d. Date signed (Mon	th. Day, Year)
1	5		30. Name and address of person with MYD MIN CM-				d Road	# 200	, Bel Ai	~ MD21014
	Sta Registi		31. Date filed (Month, Day, Year) NOV 0 1 20	05 /32. Registrar's Si	gnature	Sep.				

CT 05-06915 Magda, George

			For State Registrar	State of Ma	ıryland / Dep <i>Ce</i>	artment of F <i>rtificate of</i>	Health and N <i>Death</i>	Mental Hygi	iene 005	35206
V	Physici	an	1. Decedent's Name (First, Middle, L.					2. Date of Death Month		3. Time of Death
	/Medie	cal	George Magda  4a. Facility Name (If not institution, gi	e street and number)	-	4b City Town	or Location of Death	October	$\frac{11}{20}$	
1	Examir	ıer	2200 Old Orems 1			Middle			4c. County of Dea	
	Funeral Director		<ol> <li>Social Security Number unk 6.</li> </ol>		(In yrs. last birthday,		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov 21,	Year) 9. Bi	rthplace (State or Foreign ountry) unk
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ncation				10d. Inside City Limits
	Maryli f aho	ō	MD Balti	nore	Middle					1 Yes 2 No
	r 288	Director	10e. Street and Number	no I C	IIIddic	10f. Zip Code		10	g. Citizen of What C	
	th with		2200 Old Orems 1	Road			21220		USA	
Maryland 21215-0036	within 72 hours after death with the Maryland liene. r than "natural", or flems 23a or 28a-1 ahow The Medical Examinar must be notified at	by Funeral	11. Marital Status un  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1  Yes 2 N If Yes, Give Year or Dates:	o unk	Was Decedent of H If Yes, specify Cubin 1 ☐ Yes 2 ☑ No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecrfy Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: W	te, etc.
2-0	72 ho	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	ation during most of work	unk 1	16b. Kind of Business	Vindustry unk
21	within lene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	life.	DO NOT use retire	d)	ing		
121	filed w Hygieu ther ti		unk 17. Father's Name (First, Middle, Las	ınk		unk	18 Mother's Nam	e (First, Middle, M	faidan Sumama)	unk
and	a E b	To Be	The dates a reality (1 has, middle, 223	,		unn	TO. MOTHER'S NAME	e (Filsi, Middle, M	aluen Sumame)	ulik
ary	A PEE	F	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street	and Number or Rur	al Route Number,	City or Town, State,	Zip Code)
	1 and 2 Health a lom 27 is		O.C.M.E.		111	Penn Stre	et Baltir	nore, MD	21201	
Baltimore,			20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 {  4 □ Donation 5 ☒ Other (Special Content of the Conte	□Removalfrom State  fy) in state	20b. Place of Dispo cemetery, cre	osition (Name of matory or other plac	ce)	Date 2	Oc. Location - City or	Town, State
Ball	permit. Page Department of Importent: if any injury or once.		21. Signature of Funeral Service Lice Anthony	Rleasant			ss of Facility Omy Board MD 2120		Baltimore	Street
г			23a. Part1. Enter the disease, or con shock, or heart failure. List only	aplications that caused one cause on each lin	the death. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between
Vig	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Complic	ations of consequence of):	Chronic	Alcohol A	buse		Onset and Death
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	ed sit	Ine	ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	i consequence of):					
	xecut and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
68760,	ficate be executed physicien and is the burial-transit			d						
-	= 0	tedical	41.22	4					-1	
О. Вох	that the death certiff hed by the attending detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 1 9 ☐ Unknown	,		23d. Date of de Month	livery Day Year		
О,	es that the igned by th be detache	by Pt	Part II. Other significant conditions	contributing to death bu	t not resulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
rds	≅ % D							1 ☐ Yes	s 2 □ No 3 □ P	robably 4. Mûnknown
Division of Vital Records,	The law ate has b page 2 s	Completed						24a. Was an autopsy perform	ed? death?	utopsy findings available completion of cause of
/ita	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?					h Check only one		
<del>o</del>	d is X	6	1  Yes 2  No 27. Manner of Death	Hospital: 1 Inpatier			4   Nursing Ho		nce 6 XOther (Spe	city) Scene
Lo	ding 1 h. After funer	tlon	1 X Natural 5 🖸 Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	Wor	yat k? Yes 2 □ No	28d. Describe hov	vinjury occurred	
/isi	Attending r death. actor: After oy the fune	flca	3 Suicide 6 Could not t	O Diago of Injur	ry - At home, farm, str			28f. Location (Stre	et and Number or Ri	ural Route Number
á	ei or A s after at Direct	Certification:	4 Homicide	building, etc.	(Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town,		
	To the Mospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one)  1 Certifying P 2X Medical Exa	nysician: To the best of miner: On the basis of and manner state	examination and/or in	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occurr	and due to the cau ed at the time, dat	use(s) and manner as te and place, and due	s stated. to the cause(s)
	To th To th Comp	M	29b. Signature and title of certifier	· - ( )	1	29c. Licens	e number	290	d. Date signed (Mont	h, Day, Year)
			WILLA	V /	r \	0.C	M.E.	Oc	tober 11,	2005
			30. Name and address of person who	AIN		Print) 111 Per			ce, Maryla	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 1 200	32. Registra	r's Signature					

1	,		1 - For State Registrar	State of Maryland	/ Depa	artment of H	lealth and N Death		e2e0 0 5	35207	
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month		3. Time of Death	
	/Medic		4a. Facility Name (If not institution, give s	MOSER JR		4b City Town or	Location of Death	CUTUBER	31 20 4c. County of D		
	Examir	ier		Itospital			DALLS TUN		BATIO		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)	
I.	Director		210-30-6330	<sup>[M 2□ F</sup> 72	Yrs.	World Days	Hours Will.	Aug. 22	,1933 M	aryland	
	land w		Usual Residence of Decedent  10a. State 10b. County	10c. City, T	own or Lo	cation				10d. Inside City Limits	
	Mary -f sho	ţō	MD Baltimo	ore	Owi	ngs Mil	1 s			1 □Yes XXNo	
	h the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?	
	death with the Maryland rms 23a or 28a-f show fittust les notified at	ai D	807 Academy A	ve.		21	117		U.S.A	Α.	
	tems	Funeral		12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (San, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A	merican Indian, hite, etc.	
36	I', or	by F	1 ☐ Never Married XXMarried 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 🄀 🐧 No If Yes, Give Year or Dates:	1	☐ Yes XXNo	Specify:		Specify:	White	
Maryland 21215-0036	2 hou	ted	15. Decedent's Educ	cation 1		ent's Usual Occupa		. 10	6b. Kind of Busine		
218	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. E	kind of work done o OO NOT use retired	furing most of worl )	ring		,	
21	ed wi	Con	12		r	ruck Dr			Truck	ing	
and	i be fi	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma			
Σ	should id Me mark matic	ို	Glen E. Mose  19a. Informant's Name/Relationship (Type)		19h Mailin	n Address /Street a		therine		- Zin Codo)	
Z	nd 2 suith ar 27 is r treu		Phyllis Moser /							MD 21117	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural; or Items 23a or 28a-f show any njury or other treumatic event, the Medical Examinating the notified at ange.		20a. Method of Disposition	20b. Place	e of Dispos	sition (Name of patory or other place		-	c. Location - City		
<u>H</u>	Page nent c ent: If ury or		XXBurial 2 ☐ Cremation 3 ☐ Ro '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Ever	areen'	' 1	3/05	Finkehn	ra MD	
Salt	permit. Departr Importe any nji	Н	21. Signature of Fon and Service License	2/ 1/	22.	Name and Addres	s of Facility Ec	khardt F	uneral	Chapel P.A.	
i,	AUS e d		23a Part1. Enter the disease, or complis shock, or heart failure. List only on Immediate Causs (Final	cations that caused the death. (e cause on each line.	116	505 Reis	terstow	m Rd. Ow	ings Mi	11s, MD2111 Approximate Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	Due to (or as a cons - uen	ce of):					hours	
À	Examiner		Sequentially list conditions, b	respec	inton	face	en			Himi	
_	be isi	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a cons - uen	ce of):	U					
	icate be executed physician and s the burial-transit	xan	Cause (Disease or Irijury that initiated events resulting in death) Last Due to (or as a consequence of):								
8760,	e be e	dicai E	d								
9	tificat ng phy as th	0									
Вох	The law requires that the death certific ate has been signed by the atlending p page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea		Ectopic pregnancy			23d. Date of d	,	
0.	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐Unknown	5 🗆	Other (specify)			Month	Day Year	
Δ.	that the de led by the detached	/ Ph	Part II. Other significant conditions con	tributing to death but not resulting	g in the un	deriving cause give	n in Part I.	23e. Did toba	cco use contribute	to the cause of death?	
Records,	n signe	d by				, ,				Probably 4 Unknown	
CO	aw requir ts been s 2 should	Completed						24a. Was an	24b. Were	autopsy findings available	
	The lav	mo						autopsy performe	prior to	completion of cause of	
Viital		Be C	25. Was case referred to medical examiner?				26. Place of Deat	1 Yes 2 n (Check only one)	2110	35 2/20110	
	di S	P.	1 ☐ Yes 2 No	1	Outpatient		4 🗆 Indianing File	me 5 Residenc	e 6 □Other (Sp	ecify)	
Division of	ding Ph h. After th funeral	ertification:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	b. Time of Injury	28c. Injury Work		28d. Describe how	injury occurred		
Sic	er death	licat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home,	farm stre		′es 2□No	28f Location (Street	at and Number of	Rural Route Number.	
<u>S</u>	after Dire	ertii	4 Homicide determined	building, etc. (Specify)	, iaiiii, stie	et, lactory, office		City or Town, S		nurai noule ivurriber,	
	To the Hospitel or Attence within 24 hours after death To the Funerel Director: completely filled in by the	aic	29a. Certifier 1 Certifying Phys	icien: To the best of my knowled	dge, death	occurred at the time	e, date and place,	and due to the caus	se(s) and manner a	as stated.	
	he Ho in 24 he Fu pletel	edicai	(Check only 2 Medical Examin	er: On the basis of examination and manner stated.	and/or inve	estigation, in my op	inion, death occur	ed at the time, date	and place, and du	e to the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier			29c. License			Date signed (Mor	nth, Day, Year)	
	،		Juston	. mo.			005973	4	October	31,2005	
	10		30. Name and address of person who cor			•					
	Sta	te	31. Date filed (Month, Day, Year)	32. Pagistrar's Signature	VU FT	+1257	HUS PITAL	540	1 060	COURT ROAD	
	Registr	-	NOV 0 1 200	32. Aggistrar's Signature		and					

State of Maryland / Department of Health and Mental Hygiepe 0 5 35208 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** UCTOBER /Medical Facility Name (If not institution, give street and number) Town, or Location of Death Examiner ENBURNUE BALTIMORE WASHINGTON MEDICAL 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Days 1 M 2 XF Months Hours Min Year) Director 214-20-5441 Yrs. 80 5-9-1925 MD Usual Residence of Decedent the Manyland r 28e-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Be Completed by Funeral Director 1 ☐ Yes 2 X No Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or or other traumatic event, the Medical Examinating that be 1025 Minnetonka Rd. 21144 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2X No Specify Specify: White 3 Widowed 4 □ Divorced other than "natural". 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Edward Eble Theresa Madeline Zinkand 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health at Important: If Item 27 Is any injury or other trausonce. Paulette K. Meyd / Daughter 1025 Minnetonka Rd; Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Chesapeake Cremation 10-31-2005 Stevensville, MD 22. Name and Address of Facility Singleton Funeral Home PA 21. Sio sture of Funeral Se vi e Lic nee Second Ave SW; Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician NTRACER /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit The law requires that the death certificate be executed the attending physician and the for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 Probably 4 JUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 A No or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certific: completely filled in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the th 29b. Signature and title of certifies 29d. Date signed (Month, Day, Year) 003274 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARIA GANIRIA HOSPITAL DRIVE 31. Date filed (Month, Day, Year) Aegistrar's Signature State 2005 NOV 0 Registrar

	-			State of Maryland / Department of Health an  State of Maryland / Department of Health an  Certificate of Death		gie2e0 0 5	35209					
		Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last)  WILLIAM STEAD MCDOUGALL, SR.  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of D	2. Date of Dea Month OCTOB	Day Y ER 26, 3 4c. County of	Death					
is,	44.	Funeral Director		218-42-5965 XW 20 F 60 Yrs.	Hrs. 8. Date of Birth (Month, Day NOV • 20	, Year)	Ed Birthplace (State or Foreign Country) Maryland					
170		death with the Maryland sme 23a or 28a-f show a must be notified at	ctor	Usuaf Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Maryland Harford Bel Air			10d. Inside City Limits 1 ☐ Yes 2 📉No					
6		e 23s or 2	Funeral Director	100. Street and Number 1305 Scottsdale Drive (Unit G) 21015		USA						
16/05	9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then "naturel", or Iteme 23e or 28e-1 show eny injury or other traumatic event, Ite Medical Examiner must be notified at once.	þ	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No ff Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P	? (Specify Yes or No- Puerto Rican, etc.)	14. Hace - Black, Specify:	American Indian, White, etc. White					
10/201	1215-0	within 72 ho ene. then "natur he Wedical	Completed	15. Decedent's Education (Specify only highest grade completed)  Efementary/Secondary (0-12)  12  16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)  Truck Driver	f working	16b. Kind of Busin General	·					
	Baltimore, Maryland 21215-0036	ould be filed Mental Hygi arked other atic event,	To Be Co	17. Father's Name (First, Middle, Last) Patrick (NMN) McDougall  18. Mother's Hope	k (NMN) McDougall Hope (NMN) Brown							
25	, Mar	and 2 sho lealth and m 27 le m		19a. Informant's Name/Relationship (Type, Print)  Paulette E. McDougall/Wife  1305 Scottsdale Dr.:	ive, Bel A	ir, MD 21	015 (Unit G)					
0887	ltimore	it. Pages 1 rtment of H rtant: If Ite njury or otl		20b. Place of Disposition   Comparison   Com								
ILLIAM #0		Physician /Medical Examiner e parai-transit	edical Examiner	McComas Funeral 1317 Cokesbury I 23a. Part1. Enter the diseas and populations that caused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  McComas Funeral 1317 Cokesbury I  Due to (or as a consequence of):	Road, Abing and according to the control of the con	gdon, MD	21009 Approximate Interval Between Onset and Death					
≥ .	P.O. Box	death cer e attendir id for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date o Month	,					
776		law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			ite to the cause of death?					
046AL	of Vital Records,	S C	e Completed	25. Was case referred to medical 26. Place of	24a. Was a autop: perfor 1 Yes	sy prio med? dea 2D No 1□	re autopsy findings available r to completion of cause of th? Yes 2 \( \sum \text{No} \)					
A	f Vii	Physician: this certific ral director,	To B	examiner?  1 Yes 22 No Hospitaf: Dempatient 2 ER/Outpatient 3 DOA Cthen: 4 Nursing	Death Check only or ng Home 5 Resid		(Specify)					
Mc	Division o	Jing After fune	Certification:	27. Manner of Death    Natural   5		ow injury occurred	or Rural Route Number,					
	Div	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Certif	4 Homicide building, etc. (Specify)	City or Tow	n, State)						
		e Hosp 24 hou e Funei letely fil	edical	29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of and manner stated.	place, and due to the cooccurred at the time, o	ause(s) and mann date and place, and	er as stated. I due to the cause(s)					
		To th withir To th comp	Me	29b. Signature and title of certifier  A. A. Lee M.D. 29c. License number  29c. License number	71	29d. Date signed (1	Month, Day, Year)					
-		10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  D. D. WSHA - SIRITHARA : 211 2 BELAIR ROAD, SUITE 10	, FAUST	SW MD:	21047					
	583	Sta	te :	31. Date fifed (Month, Day, Year) 32. Registrar's Signature								

Registrar DHMH 17 Rev 1/2001

State

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3 Time of Death Day Yea **Physician** 10:10 P Calvin Dale Mullins October 28, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 120 Chatham Road Bel Air Harford If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1⊠M 2□F Yrs. Director Feb. 27, 1946 Maryland 213-46-4354 59 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show Its Modical Examinar must be notified at 1 ☐ Yes 2 No Funeral Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 120 Chatham Road 21014 12. Was Decedent Ever in U.S. Amed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 1963-85 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 end 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any injury or other traumatic svent, Item and the Las natural once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Tndepend 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Independent Elementary/Secondary (0-12) College (1-4or 5+) Automobile Dealer Automobiles 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mullins Cyble Lee Spears Melvin Joseph 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Dale Ann Mullins - W</u>ife 120 Chatham Road, Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State W Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington, Virginia \* 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat. Cem. 11/15/05 21. Signature Juneral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 23a. Part. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Uncreatie Cance Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner The law requires that the death certificate be executed attending physicien end for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has b autopsy 2 No 1□ Yes the Hospital or Attending Physiclan: 25. Was case referred to medical examiner? A Be 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c 28d. Describe how injury occurred Certification: Injury at Work? After 1 Natural
2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours efter To the Funeral Dire 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D57703 100 / Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste 107, Screek 3333 Calvert uman les N 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien 2005 35211 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death 30, Physician Mary E. McEnney 10:15 AM Oct. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Millers Carroll View Care Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May | 1905 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🙀 F Pennsylvania 175–12–3230 100 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits woye r than "natural", or iteme 23a or 28a-f ehou the Modical Examiner must be notified at 1 Yes 2 No New Windsor MD Carroll Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21776 United States 1803 New Windsor Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: White þ 3 ☐ Widowed 4 M Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Textile Mill work 8 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any linury or other traumatic avent spice. 17. Father's Name (First, Middle, Last) Be Charles Evans Nellie Jennings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) POA 4707 Vicky Road Baltimore, MD 21236 Rhonda Diggins Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 3 ☐ Other (Specify) 10/31/05 Winfield, MD South Carroll Crem. 21. Signature of Euperal Si Burrier-Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Road Winfield, MD 21784 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) NEUM ON/A Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of) Examine sicien and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medicai the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown 3 Ectopic pregnancy ŏ Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed this certificete 2 3 No 1 Yes 2□ No 1 Yes of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after upper...
To the Funeral Director: After thir 28a. Date of Injury (Month, Day Year) 27. Manne Teath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29b. Signature and Jittle of certifier 29d. Date signed (Month, Day, Year) 29c. License number lonnen and address of person with death (Item 201657 101 mark 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Sperke Registrar 2005

Amend item#22, perFH, C849, 11-1-05
State of Maryland 7 Department of Health and Mental Hygiere 05 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 29 **Physician** MILLER OCTOBER MEYER 9:00 AM 7.005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** RANDALLSTOWN HOSPITAL BALTIMORE NORTHWEST | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | North | Days | Hours | Min. | OCT | 103, 1312 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F MD 93 212-05-7093 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No by Funerai Director BALTIMORE MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21208 USA 16 OLD COURT ROAD filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 🕱 No Specify: 3 X Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) DRIVER IXAT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is marked of Pages 1 and 2 should be ROSEN MILLER CECELIA ISRAEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 7 EMERALD RIDGE COURT - BALTIMORE, MD 21209 SHEILA KESSLER / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) CHAIN 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/31/2005 HALETHORPE, MD (ANSHE EMUNAH) AITZ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Sev 22. Name and Address of Facility 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 Unter the disease, or compleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ACUTE MYOCARDO Prysician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) been signed by the a should be detached t P.O. 9☐ Unknown 9 Unknown ed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Records, 1 Yes 2 No 3 Probably 4 Wunknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 2 12 No 1 ☐ Yes Division of Vital or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 PNo 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 Homicide within 24 hours a o the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D54355 MED OCTOBER 29 2007 NOGOT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MINCEA HOSPITAL SHOU OLD COURT ROAD NORTHWEST RANDALISTONN MD 21133 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 0 1 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 5 per fh 2849 11-15-05 yt

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ma		ertificate of		nemai Hygiei Reg.	711115	35213
	Physici		Decedent's Name (First, Middle, La     SHIRLEY	•	М.	MILNER		2. Date of Death  Month  OCTODES	Day Year 200	3. Time of Death  5 01:30 AM
	/Medid Examin	-	4a, Facility Name (If not institution, giv				or Location of Death		4c County of Dea	
	Funeral Director		5. Social Geourity Number 0/4 6. S		(In yrs. last birthday	1	If Under 24 Hrs.	B. Date of Birth (Month, Day, Ye FEB.24,19	ar) 9. Bir	thplace (State or Foreign ountry)
	D		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation		1 10,27,1		10d. Inside City Limits
	e Maryl a-f sho liffed e	ctor	MD N/A		BAL	TIMORE				1 ☐ Yes 2 ☐ No
	3a or 28	I Dire	10e. Street and Number 7218 PARK HEIGH	TS AVENUE		10f. Zip Code	21208	10g.	Citizen of What Co	ountry? USA
0	be filed within 72 hours after death with the Maryland viely gione. Hygiane did Hygiane did thy sine matter in the Medical Examiner must be notified at evant, the Medical Examiner must be notified at	y Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1  Yes 2 X No		Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	erican Indian,
o-0020	'2 hours natural', ical Exp	ted by	3 X Widowed 4 □ Divorced  15. Decedent's E	Year or Dates: lucation	16a. Dec	edent's Usual Occur	pation	16b	. Kind of Business	
7 7 7	s filed within 72 hours I Hygiene. othar than "natural", vant, the Medical Exa	Completed	(Specify only highest graves   Elementary/Secondary (0-12)   12	College (1-4or 5-	-)	RETARY	during most of work		IOLESALE	DISTRIBUTOR
	be d all all all all all all all all all a	Be	17. Father's Name (First, Middle, Last)  JOSEPH		ROXI	ΓN	18. Mother's Name	e (First, Middle, Maid		NAVINSKY
ary	2 should be and Menta Is marked aumatic ev	2	19a. Informant's Name/Relationship (	**				al Route Number, Cit		
e) E	1 and Health am 27 Ithar tr		SHELDON MILNER  20a. Method of Disposition	/ SON	20b. Place of Disp	osition (Name of		TIMORE, MD	21209 Location - City or	Town State
Ē	Pages nent of int: If it iry or o		1 A Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specif		cemetery, cre	matory or other pla	ISRAEL 10	200.	BALTIMOR	
Бант	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Pervice Licen	Sugar.	2	2. Name and Addre	ess of Facility SOL	LEVINSON ROAD - PIK	& BROS.	, INC.
			23a. Part 1. Enter the disease, or comshock, or heart failure. List only	one cause on each line	the death. Do not er e.					Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. SEP:	consequence of):					2 week
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DIVIS	To the Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: After completely filled in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injurbuilding, etc.	ry - At home, farm, si (Specify)	reet, factory, office		28f. Location (Street City or Town, Sta	and Number or Ru ate)	ural Route Number,
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	To the Within To the compli	Me	29b. Signature and title of certifier		1	29c. Licens		29d. [	Date signed (Monti	h, Day, Year)
	1		30. Name and address of person who	completed cause of de-	ath (Item 23a) (Type	Print SAN	1089466 L	SWANN	TUDEN 2	28,2005 21218-2895
	10		Union Memorial	HOSPITAL	201 6.6	piversity	BRKWA	Baltim	ore MD.	21218-2895
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	Examin		4a. Facility Name (If not institution, gir	ve street and number)	. \	4b. (	City Town,	or Location of Death		4c. County of De	
			Franklin Squa	re Hospi	tal		K05	sedale		Batti	more
	- Funeral			Sex 71 Ag 1 ☑ M 2 ☐ F		Mon	nder 1 Year ths Days		8. Date of Birth (Month, Day	(Year) 9. E	irthplace (State or Foreign Country)
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	show		10a. State 10b. County		10c. City	, Town or Location					10d. Inside City Limits
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	or 28;	Director	10e. Street and Number			10f	f. Zip Code	<del>-</del>	1	10g. Citizen of What	Country?
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	ar dea	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.	S. 13. Was D If Yes,	ecedent of i	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Ar Black, Wh	nerican Indian,
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ار 10 ا	item 27		Andrew F. Nov	ak Jr. /s	son	9641 I		Place H			T
\(\frac{1}{2}\)	nt of 1		1 ☐ Burial 2 🖸 Cremation 3 [		C6	emetery, crematory YV1ewCre	or other pla	ce)		20c. Location · City of Baltimo	re MD
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Division of Vital Records, P.O.	es tha	<b>by</b> P	Part II. Other significant conditions	contributing to death bu	at not resu	Iting in the underlying	ng cause giv	en in Part I.			to the cause of death?
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<u>Visi</u>	Attsu or dea octor by the	Iffice	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ry - At hor	ne, farm, street, fac	ctory, office		28f. Location (St	reet and Number or F	Rural Route Number,
ō	tal or rs afte sl Dir ed in	Certification:	Tiomicide	building, etc	. (Брөсіту	)		9.0	City or Town	n, State)	
	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 Certifying Pt	hysician: To the best of miner: On the basis of	of my knov	viedge, death occur	rred at the tir	ne, date and place,	and due to the ca	ause(s) and manner a	s stated.
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	or with	<	29b. Signature and title of confifier	1			29c. Licens			9d. Date signed (Mor	
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	Pogietr	25	11011 A	1 20hE N		M. Book	2191				

CPM 05-07199 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Charles Naumann, Jr. Amend item#2, per WE 0852,2/16/06/Department of Health and Mental Hygiezen 05 35215 For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician October 2005 17:13 Charles Naumann Jr /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town or Location of Death Examiner 2213 Harvest Farm Road Svkesville Carrol1 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1√2 M 2□ F Yrs Dec 29, Director 69 Maryland 216-32-9223 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 28a-f ahow traumatic avant, the Medical Examiner must be notified at 1 Yes 2 No Director MD Sykesville Carrol1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 21784 USA 'natural', or Itema 23a 2213 Harvest FArm Road death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. e filed within 72 hours after all Hygiene.
other than "natural", or Item 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 5+ teacher education 17. Father's Name (First, Middle, Last) 18 Mother's Name /First Middle Maiden Sumame permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic avant 9088. Be Christine Irene Becker Charles Edwin Naumann ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2213 Harvest Farm Road Sykesville, MD 21784 Linda Naumann/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee
Anthony Pleasant <sup>22</sup> Name and Address of Facility State Anatomy Board 655 W. Baltimore Street nyrony 21201 Baltimore, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final atherosc **Physician** disease or condition resulting in death) Cardiovasculor discose /Medical Due to (or as a consequence of): Examiner fequentially list ou ditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine been signed by the attending physician and should be detached for use as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Nnknown Completed 24a. Was an autopsy performed? s certificate has the 1 Yes 2 🗌 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1∑Yes 2□ No 2 ER/Outpatient 3 DOA 4□ Nursing Home 5□ Residence 6 Nother (Specify) SCENE ဥ 1 Inpatient this After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director; / completely filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME October 25, 2005 llel us

State Registrar 31. Date filed (Month, Day, Year) 32. R

32. Registrar's Signature

A Arask

30. Manye and address of person who completed cause of death (frem 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygieze 0 0 5 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6:30 PM wens 0 30-05 erou /Medical 4b. City, Town, or Location of Death nstitution, give street and number) 4c. County of Death Examiner Baltimore 8. Date of Birth (Month, Day, (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) Number **Funeral** Days Min. Months Hours Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show other traumatic event, the Medical Examinar must be notified at Himore 1 Yes 2 □ No **Funeral Director** 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ 21225 USA or iteme 23a Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11 Marital Status filed within 72 hours after 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 4 Divorced Specify: Black Be Completed by 3 Widowed "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) pera-tor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) rmit. Pages 1 and 2 should be filt partment of Health and Mental Hy portant: If Item 27 is marked oth y injury or other traumatic eventy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Audress (S) eet and Number City of Town, State, Zip Code) Daughter 404

20b. Place of Disposition (Name of cemetery, crematory or other) listown mb aliss Method of Disposition Garrison Burial 2 Cremation 3 Removal from State permit. Page Department o important: if any injury or 1 Burial 2 □ Cremation 3 □ H 4 □ Donation 5 □ Other (Specify) 21. Sign ture of un rai Service stown, MD 21133 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Col cancer /Medical Due to (or as a consequence of) Examiner S. uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attanding Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760. led by the attending physicien detached for use as the burial Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, page 2 should be 1 Yes 2 No 3 Probably 4 Minknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 2 No 1 Yes No No 1 Yes filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After ! 5 Pending investigation M 1 ☐ Yes 2 ☐ No death. after death 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours aft To the Funeral Di completely filled in 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2005 Y completed cause of death (Item 23a) (Type, Print) 838 N. Eutawst. Baltimore 31. Date filed (Mod Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien 0.05Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Physician 10:30 am 30 10 wens 2005 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4510 & Old Court Road Pikesville
If Under 1 Year If Under 24 Hrs. Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 X F 218 - 38 - HOH Usual Residence of Decedent Yrs. Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or iteme 23a or 28e-f ehov the Medical Examiner navet be nutified at Pikesville MD Baltimore 1 Yes 2 No Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Yomana North 21208 V.S.A. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No li Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore City Pages 1 and 2 should be filed within nent of Health and Mental Hygiene ant: If item 27 is marked other than " College (1-4or 5+) Elementary/Secondary (0-12) School Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pomona North Apt #5 rae lleice shelly Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/03/05 Injury or Department Important: It any Injury o 22. Name and Address of Facility Vaugin C. Greene Funeral Sives. 21. Signature of Funeral Service Licensee U Randallstown, NO 21133 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ears /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examine -transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed and physicien ar Due to (or as a consequence of): Box 68760, Physician/Medical attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ፩ 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Medical Certification; To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 → Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Mann of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death.

• Funeral Director: A 2 Accident the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hou To the Fune completely fi 29b. Signature an 29c. License number 29d. Date signed (Month, Day, Year) OK address of person who completed cause of death (Item 23a) (Type, Print) 3635 is MACMON 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

			1 - For State of Maryland /	Depa	artment of Health artificate of Death	and M	ental Hygie	_		35218
			Decedent's Name (First, Middle, Last)				2. Date of Death			3. Time of Death
	Physicia /Medic		Idelle M. Ogburn				October	26, 20	105"	2:35 P M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of	of Death		4c. County	of Death	
			Manor Care Rossville	- trade of the	Baltimore	O.4 Ump		Balti		
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 1 7. Age (In yrs. last b	Yrs.	If Under 1 Year If Under Months Days Hours	Min.	8. Date of Birth (Month, Day, ) Sept. 2,	1916	9. Birth Cou Mai	place (State or Foreign ntry) Cyland
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, To	wn or Lo	cation					10d. Inside City Limits
	be filed within 72 hours after death with the Maryland ttal Hygiene. Id other than "natural", or Itema 23a or 28a-1 show event, The Medical Evarriest must be multied at	tor	MD Baltimore Balt	imor	e					1 □ Yes 2 🍎 No
	or 28g	Funeral Director	10e. Street and Number		10f. Zip Code		100	g. Citizen of V	Vhat Cou	intry?
	ath wi	rai	31 Sipple Ave.		21 236			USA	1	
	er des Itema	une	11, Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of Hispanic Ori f Yes, specify Cuban, Mexican	igin? (Spe n, Puerto l	cify Yes or No- Rican, etc.)		e - Ameri k, White,	can Indian, , etc.
36	urs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No If Yes, Give 3 🔀 Widowed 4 ☐ Divorced Year or Dates:		1 ☐ Yes 2 🕅 No Specify:			Specify	:	White
9-0	72 hou	ted	15. Decedent's Education 16	a. Dece	dent's Usual Occupation		16	6b. Kind of Bu	siness/Ir	ndustry
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121	e filed within al Hygiene. I other than " vent, the Me		12	Hom	emaker		(F) . All (   )		in Ho	me
/land	should be fi nd Mental H marked ot umatic ever	To Be	Lee K. McBee		18. Mothe	ers Name Ella	(First, Middle, Ma	uden Surnam	·e)	
Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en		19a. Informant's Name/Relationship (Type, Print)  Kathleen A. Seiler (daughter)		ng Address (Street and Number Sipple Ave., E					<sup>D Code)</sup> 21 2 3 6
ore,	es 1 a of Hea litem r othe		20a. Method of Disposition 20b. Place camel	of Dispo	sition (Name of natory or other place)	n/20	<sup>2</sup> 2005	c. Location -		
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Baltimore,	permit. Depart Import any inj		21. Signification of the Stephen Coster		. Name and Address of Facilit					lome, Inc. 204
î.			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one caus i on each line.	o not ent	er the mode of dying, such as	cardiac o	r respiratory arres	t,		Approximate Interval Between
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	*	er	Sequentially list conditions, farry leading to immediate.	e of					(	CVAION 19
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
oʻ	an an rrial-tr	Еха	resulting in death) Last Due to (or as a consequence	e of):						
8760,	death certificate be executed e attending physician and of for use as the burial-transit	licai	d							
9 ×	eath certifica attending ph for use as th	/Med	IF FEMALE:							
Вох	attend for us	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 2 ☐ Horsows		Ectopic pregnancy Other (specify)			23d. Dat Mor		ery Day Year
P.O.	the y th	nysic	1   Yes 2   No 9   Unknown	31.	1 Other (specify)					S
	law requires that the sas been signed by 2 should be detact	by Pr	Part II. Other significant conditions contributing to death but not resulting	in the u	nderlying cause given in Part I.		23e. Did toba	cco use contr	ibute to t	he cause of death?
Records,	w require been sig should b						1 ☐ Yes	2 Nio	3 🗌 Prob	babiy 4 🗀 Unknown
ecc	e law re has be je 2 sho	piet					24a. Was an autopsy			opsy findings available ompletion of cause of
= H	Th ate pag	Completed					performe	<b>9</b> ?	eath?	2□ No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?		20.56	of Death	Check on one			
of	this al dii	٦.	1 Inpatient 2 ER/C	Outpatien Time of			ne 5 Resident			(y)
on	ding P h. After funer	tion	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	Injury	Work? M 1 ☐ Yes 2 ☐	- 1	8d. Describe how	injury occurr	au	
Division	ii or Attending after death. I Director: Afte d in by the fune	ertification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home,	farm, str		2			er or Rum	al Route Number,
	ital or irs afte ral Dir lled in	O	Salaria, sto. (Specify)				City or Town,			
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowled, 2 Medical Examiner: On the basis of examination a and prapher stated.	ge, deatl and/or in	n occurred at the time, date an vestigation, in my opinion, dea	nd place, a oth occurre	nd due to the caused at the time, date	se(s) and ma and place, a	nner as s und due to	stated. o the cause(s)
	To t To t	Σ	29b. Signature and title of pertifier		29c. License number		29d	. Date signed	(Month,	Day, Year)
F			1.000		1)45	41	5	10/	6	~
			30. Name and address of person who completed cause of death (Item 23a Dr. Mohammad Rahnama 9512 Harf		Rgad, Baltimo:	re. M	1D. 2123	34		
	Sta	te	31. Date filed (Month, Day, Year) 1 2005 32. Registrar's Signature		boote	, '				
	Registr		MAA A T SOOD							

			For State Registrar	State of M	Maryland	l / Depa <i>Cei</i>	artment of F tificate of	lealth ar Death	nd Mental	Hygiere Reg. No	005	35219
3.	- 3	- 26	1. Decedent's Name (First, Middle	e, Last)	-				2. Date of Month		y Year	3. Time of Death
	Physici /Medic		Robert	Philip	Parkin	nson			Oct			4:56 A M
	Examin	100	4a. Facility Name (If not institution	n, give street and number	er)		4b. City, Town, o	r Location of I	Death	40	. County of Deat	
			Holy Cross H	ospital				Sprin			Montgon	nery
9.	Funeral		5. Social Security Number	6. Sex 7 1(X) M 2 ☐ F	Age (In yrs. la:		If Under 1 Year Months Days		Hrs. 8. Date of Min. (Monti	f Birth n, Day, Year)	9. Birt	thplace (State or Foreign ountry)
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	D .		Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	cation					10d. Inside City Limits
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	with the page of t	ă	3144 Gracefie	old Rd.				904			ited Sta	
	72 hours after death with the Maryland natural; or itame 23a or 28a-f show dical Examinat must be notified at	Funeral Director		12. Was Decede	nt Ever in IIS	13 \			2 (Specify Ves		14. Race - Ame	
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36	i', or	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	es:		1 ☐ Yes 2 🂢 No	Specify:			Specify:	White
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ary	shot and h		19a. Informant's Name/Relations				ng Address (Street					Zip Code)
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re	ges 1 and 2 of Health if itam 27 is		20a. Method of Disposition	2 []]	1 001	ice of Dispo	sition (Name of natory or other pla	ce)	Date	20c. L	ocation - City or	Town, State
Ĕ	Page nent c	١,	1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other (S		Ches	sapeak	e Cremat	ory 1	0/29/05	Ве	eltsvill	e, MD
ä	permit. Pages 1 Department of H Important: if its any injury or ot once.		21. Signature of Funeral Service	Licensee		22	. Name and Addre	ss of Facility	d Cromat	ion S	arvioos	
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7	275		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause on each	sed the death.	Do not ent	er the mode of dyir	ng, such as ca	rdiac or respirat	ory arrest,		Approximate Interval Between
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Division	Attending r death. ector: After by the fune	Certification	2 ☐ Accident investi	igation			M 1	Yes 2 ☐ No	0			
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	To To con	Σ	29b. Signature and title of contine	LAV			29c. Licens			29d. Da	ate signed (Mont	n, Uay, rear)
				XX			D6	2885		10	12/10	5
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	10		Sonja Wyche M.I					r Spri	ng, MD	20910		
	Sta		31. Date filed (Month, Day, Year,	32. Red 0 1 2005	istrar's Signati	ure	Soule					
	Regist	ell	NOV	1 Troop	The state of the s	.5	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere 05 35220 1 - For Stata Registrar Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2:54A **Physician** Ochker 29 2005 odne. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hopkins 6. Sex Baltimore N/A HOSPITal CITY Johns If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Bay. Jan 23, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1940 1XM 2□F 65 219-26-7034 Yrs. Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28e-f show must be notified at 1 ☐ Yes 2 No Director Linthicum Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zin Code 10e Street and Number **USA** 21090 Items 23a 402 Beechwood Road Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. the Mudical Examiner 1 XYes 2 No 1957 If Yes, Give Year or Dates: 1960 1 Never Married 2 Married ŏ 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 X Divorced "netural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Steel Industry Truck Driver .. Pages 1 and 2 should be filed wil tment of Health and Mental Hygien-tant: If Item 27 Is marked other th-ijury or other traumatic event, Ite 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lottie Kaufman Charles A. Plank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie L. Sasse, Daughter 949 Ashcreek Drive Centerville, Ohio 45458 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of Important: If It any injury or o 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory Inc. 11/02/05 `4 □ Donation 5 □ Other (Specify) Baltimore, Maryland MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 21. Signature of Funeral Service Licer Thomas Gregor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Failure days Physician /Medical Due to (or a a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit color Due to (or as a consequence of) physician Physician/Medical the 28 IF FEMALE: 981 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? res 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28b. Time of 28a. Date of Injury Certification: Month, Day Injury 5 Pending investigation 2 🗆 No 1 Tes 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

be executed Box 68760 P.O. Division of Vital Records,

with the Maryland

death

illed within 72 hours after

Baltimore, Maryland 21215-0036

e Hospital or Attending Pl 24 hours after death. e Funeral Director: After the 24 hours a

> State Registrar

To the

29a. Certifier

(Check only one)

31. Date filed (Month, Day, Year)

Medical

29b. Signature and title of certific nd address of person

1 2005

MD

KES 000

Positiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) Octuber 29 2005

N. Wolfe Street Beltimore MD

impleted cause of death (Item 23a) (Type, Print)

Coun MD

32. Registrar's Signature

			State of Maryland /  1- State Registrar	Department of Health and No Certificate of Death	Mental Hygier Rog.	'uua .	35221
	183 2	10	Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia /Medic		Maria Prosperi			Day Year 2005	09345Am
	Examin		4a. Facility Name (If not institution, give street and number)  Penns (III) KANINGA MINICAL CONFU	4b. City, Town, or Location of Death		4c. County of Death	٨
			FINISHIA REGIONAL MEDICAL CONFLO 5. Social Security Number 6. Sex 7. Age (In yrs. last b	irthday) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth		elace (State or Foreign
	Funeral Director		335–28–7589 1□ M 2√F 103	Yrs. Months Days Hours Min.	(Month, Day, Yea	1902 Spat	ntry)
	ס		Usual Residence of Decedent		Julie 20;		
	arylar ehow	_		wn or Location		1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	ecto	MD Wicomico Sa.  10e. Street and Number	lisbury	100	Citizen of What Coun	
	with land	io	106 W. Vine Street		rog.		my :
	ma 2%	hera	11. Marital Status 12. Was Decedent Ever in U.S.	21801  13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Americ	
ဖွ	within 72 hours after death with the Maryland ane. than "natural", or itema 23e or 28e-f ehow ine Medical Exercinar must be notified at	by Funeral Director	Armed Forces?  1 Never Married 2 Married 1 Yes, Give	If Yes, specify Cuban, Mexican, Puerti		Black, White,	
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15-	in 72 in 72 in all	Completed	(Specify only highest grade completed)	<ul> <li>Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)</li> </ul>	king unk 166.	. Kind of Business/Ind	dustry unk
212	y withi	шо	Elementary/Secondary (0-12) College (1-4or 5+) unk unk				
פַ	e filec al Hyg othe vent,	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Nan	ne (First, Middle, Maid	len Surname)	
lai	Menta Menta arked atic e	70	Juan Bonet Carbo	Carme	en Ripolles	5	
Maryland	2 sho		19a. Informant's Name/Relationship (Type, Print)  Lydia Crumbacker/daughter	b. Mailing Address (Street and Number or Ru			Code)
e, P	1 and dealth om 27 ther t			316 Locust Terrace S		MD 21801  Location - City or To	own State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturat", or iteme 23s or 28s-1 show any injury or other traumatic event, the Medical Exercitat must be notified at once.			ery, crematory or other place)			
Balt	permit. Departi		21. Signature of Funeral Service Licensee Anthory Deleasant	22. Name and Address of Facility State Anatomy Boa: Baltimore, MD 212	rd 655 W. I	Baltimore	Street
H			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition CONG & CAUR	HEART FAILUR	Le		Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence				
В	Lxummer	35	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence	a of):			
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oʻ	cate be executed physician and the burial-transit		that initiated events c	e of):			
8760,	ate be hysicia the bu	dicai	d				
9			IF FEMALE:				
Вох	death certifi e attending i id for use as	Physician/Me	23b. Was decedent pregnant 12b. in the past 12 months?	th 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ary Day Year
o.	D 0 0	ysic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death	5 Uther (specify)			
<u>α</u>	The law requires that the tite has been signed by th bage 2 should be detache	by Ph	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the	ne cause of death?
Vital Records,	quires in signe				1 🗌 Yes	2 No 3 Prob	ably 4 Unknown
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/ita	sician: T certificat irector, pa	BeC	25. Was case referred to medical examiner?		th (Check only one)	1 m t	
of V	Physician: this certific ral director,	ဥ	1 Yes 2 No Hospital: 1 Inpatient 2 ER/C		ome 5 Residence		y)
n C	After Aunel	ion:	Natural 5 ☐ Pending (Month, Day Year)	. Time of lnjury at Work?  M 1 □ Yes 2 □ No	28d. Describe how in	njury occurred	
Division	or Attending after death. I Director: After d in by the fune	ficat	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home.			and Number or Rura	al Route Number,
<u>S</u>	el or safter	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, St.	ate)	
	To the Hospitel or a within 24 hours after To the Funerel Direction completely filled in b	edicai (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	ge, death occurred at the time, date and place and/or investigation, in my opinion, death occu	, and due to the cause rred at the time, date a	e(s) and manner as si and place, and due to	tated. the cause(s)
	To the within To the complete	Me	29b. Signature and title of certifier	29c. License number	29d. I	Date signed (Month,	Day, Year)
•			/au (July	224872		0/24/0	5
			30. Name and address of person who completed cause of death (Item 23a)	TENTH ST 1	Pocomolo	Elly N	0
10000000000000000000000000000000000000	Sta Registi		31. Date filed (Month, Day, Year)  32. Registrar's Signature	Louis .			
				7			

Maria Prosperi 335-28-7589

	L FLARS	OIV.	state Unpend It	State em 23a&27	of Mary per m	land / Depa e G849 Ce	artment of H 1-7-05 tiflcate of	lealth and I Beath	Mental Hy	gieze	5	35222		
las E	Physici	an	1. Decedent's Name (First, Midd						2. Date of De Month	Day	Year	3. Time of Death		
s II	/Medi	al	Willie 4a. Facility Name (If not institution			earson	45 Ch. Taux	A Company of Company	OCT.	24, 200		0708 A M		
9	Examir	er	1903 HUGUENO	T PLACE	number)			Location of Death		4c. County ANNE	ARUI	NDEL		
9	Funeral Director		5. Social Security Number 409–46–8496	6. Sex 1X M 2 ☐ F		yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 9-26-1	th 17, Year) 933	Cour	elace (State or Foreign htry) abama		
	iand ow		Usual Residence of Decedent  10a. State 10b. Count	y	100	c. City, Town or Lo	ocation				1	0d. Inside City Limits		
	e-feh	ctor	MD Anne	ARundel		Seve	ern					1 ☐ Yes 2X No		
	with th	Funeral Director	10e. Street and Number 1903 Huguenot	· Place			10f. Zip Code 2114	'. <i>I</i> .		10g. Citizen of V USA	Vhat Cour	ntry?		
	me 23	neral	11. Marital Status	12. Was D	ecedent Ever	in U.S. 13.	Was Decedent of H	ispanic Origin? (St	pecify Yes or No	- 14. Race		an Indian,		
980	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23e or 28e-f ehow any injury or other traumatic event, If a Medical Examinal number to notified at ance.	þ	1 ☐ Never Married 2 ☐ Ma	rried 1 X Ye	l Forces? es 2 □ No Give er Dates:	i	If Yes, specify Cuba 1 ☐ Yes 2X No		o Rican, etc.)	Specify	k, White,	<sub>etc.</sub> ack		
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pu	e filed al Hyg d other	BeC	17. Father's Name (First, Middle							Maiden Surnam	e)			
Ŋ	d Menid h	P	Henry Pearson			10h Mail	- Add (64		zella Pearson ber or Rural Route Number, City or Town, State, Zip Code)					
	nd 2 sh lith and 27 is n r traur		Ms. Nicole Pea		ghter				evern, MD 21144			Code)		
ore,	es 1 au of Hea litam rothe		20a. Method of Disposition 1 XBurial 2 ☐ Cremation	`	20	e)	Date	20c. Location -		wn, State				
Baltimore,	tment tant: tant: b		4 □Donation 5 □ Other	(Specify)	I State		/31/05 Crownsville, MD Gingleton Funeral Home P.A.							
Bal	permii Depar Impoi any ir		21. Signature of Funeral Service	e Lidensee	M	ss of Facility Si ave SW G1				e P.A.				
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o L	er fe	lon:	27. Manner of Death 1 X Natural 5 ☐ Pend		ite of Injury fonth, Day Yea	28b. Time of Injury	Work		28d. Describe f	now injury occurre	be			
isio	Attendictor: death	Certification:	3 ☐ Suicide 6 ☐ Could	mined   288. Pli	ace of Injury -	At home, farm, str		Yes 2□No	28f. Location (S	Street and Numbe	or or Rura	l Route Number.		
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	To the Hospital or within 24 hours after To the Funeral Direction completely filled in b	Medical	29a. Certifier 1 Certify (Check only one) 2 Medica	il Examiner: On the	the best of my e basis of exam anner stated.	knowledge, death mination and/or in	n occurred at the time vestigation, in my op	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and mar date and place, a	nner as st nd due to	ated. the cause(s)		
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			> Chiese							OCT. 25				
	~		30. Name and address of person	RUBLO,	110			enn Stree	et Balt	imore, M	1aryl	and 21201		
**	Sta Registi		31. Date filed (Month, Day, Year NOV 0	1 2005	2. Registrar's S	Signature	north							

Physiciar	1	State Registrar	State of W	arylan	Cer	tificate of	lealth and M Death		gienne Reg. No.	005	35223
Dhweiciai		1. Decedent's Name (First, Middle	, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
/Medica		John Raymond	Pancella					Octobe	er 27		1420
Examine		4a. Facility Name (If not institution,	give street and number)	)		4b. City, Town, or	Location of Death		4c. C	ounty of Death	ı
		Montgomery Hos	spice Casey	House	2	Rockvil				ontgome	ry
al				ge (in yrs. i	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da	th v. Year)	9. Birth	place (State or Foreig
r		164-28-8577	1 <b>∑</b> M 2□F	74	Yrs.	,		June 2	4, 19	31 Pen	nsylvania
	}	Usual Residence of Decedent  10a. State 10b. County		10c Cit	, Town or Lo	reation					10d. Inside City Limits
١,											1)X Yes 2 □ No
	Director	Maryland Montg	omery	Roc	<u>kville</u>				15 000		
To De Operational Property	2	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Cou	intry?
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		11. Marital Status	12. Was Decedent Armed Forces? ed 1 X Yes 2 □	?	3.	was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spann, Mexican, Puerto	Rican, etc.)	- 14	. Race - Amer Black, White	
	D.	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give Year or Dates:	195		1 ☐ Yes 2X No	Specify:		s	pecify:	• •
		15. Decedent'				dent's Usual Occup	ation		16h Kina	Wh of Business/li	ite
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3	<u>ح</u>	17. Father's Name (First, Middle, L	<u> </u>		PCTEI	ice bupel	18. Mother's Name	e (First, Middle			OOTS
	ď	Joseph Pancel					Angela	•		,	
F	2	19a. Informant's Name/Relationsh			10h Mailie	- Address (Ctract				Form Chair 7	p Code) 20886
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	J	Joanne Marcello  20a. Method of Disposition	/Partner	20h P		O Highlan esition (Name of		ive, Mc		nery Vi	11age, MD
		1 ☐ Burial 2 🎇 Cremation		a	emetery, cren	natory or other plac		ber 30,	200. 2006	tion · Oity or i	Own, State
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1	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnancy			23	d. Date of deliv	•
- 1 -	<u> </u>	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a 9☐Unknown			Other (specify)				Month	Day Year
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Carlette To Complete Property	Certification; 10 se Completed by	25. Was case referred to medical examiner?  1	Hospital: 1 Inpation  28a. Date of Inju (Month, Da  ation  ont be oned  28e. Place of In building, ei  g Physician: To the best examinar: On the basis of and manner st	ent 2 ury ay Year) jury - At hctc. (Specify of my kno	ER/Outpatien 28b. Time of Injury ome, farm, str	at 3 DOA Cth  f 28c. Injun Wor M 1 = eet, factory, office n occurred at the tim vestigation, in my o	26. Place of Deather: 4 □ Nursing Hoy at k? Yes 2 □ No	24a. Was autor period 1 Yes 1 Yes 28d. Describe I 28d. Location (3 City or Toward due to the ed at the time,	an sy med? 2 \( \sum \) No me)  dence 6 (\) now injury (\) Street and wn, State)  cause(s) at date and p	No 3 Pro  24b. Were aut prior to co death? 1 Yes  Mother (Special occurred	opsy findings availably impletion of cause of 2 No  No  No  Hospice  al Route Number,  stated. o the cause(s)
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			1 - For State Registrar	State of Marylan	d / Dep <i>Ce</i>	partment of H ertificate of I	lealth and M Death	fental Hyg	iene2 0 0 5	35224
l	Physici	an	1. Decedent's Name (First, Middle, La: Marie L. Petrenko	st)				2. Date of Deat Month	Day Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of Death	Octobe	27, 2005	
	Funeral Director		Manor Care-Potor  5. Social Security Number  5.78-22-7812  Usual Residence of Decedent		ast birthday Yrs.	Potomac // If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 10	Montgome 9. Bi 1911 New	theless (Otate on Femilia)
	yland how		10a. State 10b. County		, Town or l					10d. Inside City Limits
	Be-f	ector	Maryland Montgome	ery	Rockvi					1 ☑ Yes 2 □ No
	23a or 2	Funeral Director	10e. Street and Number 1715 Evelyn Drive			10f. Zip Code 20852			Og. Citizen of What C United Sta	•
2-0030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Depertment: If Item 27 is marked other then "natural", or Items 23a or 28e-f show eny injury or other traumatic event, the Mardical Extrained client be nufficed at ODGE.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	S. 13	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Spi in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
0-0171	within 72 ho ene. then "natur ne wed cal	ompleted	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed)  College (1-4or 5+) 5+	16a. Dec (Giv life. Educa	edent's Usual Occup re kind of work done o DO NOT use retired	ation during most of work ()	ing 1	16b. Kind of Business Montgomery Public Sch	County
ana	e filed at Hygi I other vent, I	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, A	Maiden Sumame)	
) Aga	nould b	2	Michael Lapinski					Nazarev		
<u>0</u>	nd 2 st alth and 27 ls n r treun		19a. Informant's Name/Relationship ( Michael Petrenko						City or Town, State, Dale, Mar	yland 20769
more,	Pages 1 and neut of Heamant: If Item		20a. Method of Disposition  1 ⊠ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif.	Removal from State	emetery, cri e Of He	position (Name of ematory or other place aven Cemeter	9) Octob y 200	er 29, 5		ing, Maryland
Dall	permit. Depertr Imports eny Inju		21. Signature of Funeral Service Licer		.433 F	22. Name and Address Rockville,	is of FacilityRobe Inc. 300 Maryland	ert A. P	umphrey Funtgomery	neral Home Avenue
	Pnysician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		. Do not e	nter the mode of dyin	g, such as cardiac o	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Examiner pu	Examiner	Sequentially list conditions, any leading to anni adiase cause. Enter Underlying Cause (Disease or injury that initiated events	b. — Due to (or as a consecu	ienna sf):					
00/00	ficate be executed physicien and is the burial-transit	edical Ex	resulting in death) Last	Due to (or as a consequent	ience of):					
DOX .	aath certii attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	olivery Day Year
cords, r	ie faw requires that the de has been signed by the i ge 2 should be detached	þ	Part II. Other significant conditions of	contributing to death but not resu	ulting in the	underlying cause give	en in Part I.		_	o the cause of death?
l reco	The taw re- cete has bee page 2 sho	Completed						24a. Was ar autops perform 1 Yes 2	ned? death?	utopsy findings available completion of cause of
)   	slcian: certific irector,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1   Inpatient 2	FD/0	ent 3 DOA Othe	26. Place of Death		•	
0 10	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this cartificate ha completely filled in by the funeral director, page	-	27. Manner of Death  1 🖾 Natural 5 🗆 Pending 2 🗀 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of 28c. Injury	4 Kul Nursing Ho		nce 6 □Other (Spe w injury occurred	ecity)
DIVISION	safter des safter des al Directo ad in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		me, farm, s	street, factory, office		28f. Location (Str City or Town	reet and Number or R , State)	ural Route Number,
	ne Hospit n 24 hour he Funera sletely fill∉	edical (	29a. Certifier 1 Certifying Ph	ysician: To the best of my known on the basis of examination and manner stated.	wledge, dea ion and/or i	ath occurred at the time.	ne, date and place, pinion, death occurr	and due to the ca ed at the time, da	use(s) and manner a ite and place, and du	s stated. e to the cause(s)
,	Tott withi Tott	Ž	29b. Signature and little of certifier	<b>&gt;</b>		29c. License D0054		,	od. Date signed (Mon tober 28,	
			30. Name and address of person who Sunitha Bhogavill:	i, M.D. 1220 A F	ast J		, Towson,	Marylar	nd 21286	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 1 2	32. Registrar's Signa		Caste 8				

				1 - State Amend Item 29d per Dr., C	and / Dep <b>3849, 11</b> ,	partment of /01/05dbh	Health and M Death	lental Hygi	eme 0 0 5	35225
		Dhysici		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Y	3. Time of Death
	ij,	Physici /Medic	rich.	SANDRA M. ROE				OGOBER		201 10:50 AM
		Examin	er	4a. Facility Name (If not institution, give street and number)  St. AGNES Harplot TAL.		4b. City, Town, BALT	or Location of Death		4c. County of BAL	TIMORE
•	~	Funeral Director	A.	5. Social Security Number  2 16 - 66 - 2577  6. Sex 1 □ M 2 💢 F  7. Age (In y	yrs. last birthday 5/ Yrs.	y) If Under 1 Year Months Days		8. Date of Birth (Month, Day, MARCH I	79ar) 3,1954	Birthplace (State or Foreign Country)
		land ow		Usual Residence of Decedent  10a. State 10b. County 10c.	. City, Town or I	Location				10d. Inside City Limits
•		a-f sh	ctor	MD BALTIMORE	BA	LTIMOR	E			1 Yes 2 □ No
		with the	Director	10e. Street and Number 5104 CHESTNUT AVE.		10f. Zip Code	1227	10	g. Citizen of Wha	
		Jeath The 23	erai	11 Marital Status 12. Was Decedent Ever ii	n U.S. 13	B. Was Decedent of	Hispanic Origin? (Spe	ecify Yes or No-	14. Race -	American Indian,
	920	within 72 hours after death with the Maryland ene. than "netural", or items 23a or 28a-f show the Marical Exeminer must be notilliad at	by Funeral	Armed Forces?  1 Never Married 2 Married   1 Yes 2 No   1 Yes 2 No   1 Yes (3 No   1 Y		If Yes, specify Cul	ban, Mexican, Puerto	Rican, etc.)		White, etc. WHITE
1	21215-0036	72 ho	Be Completed	15. Decedent's Education (Specify only highest grade completed)	(Giv	cedent's Usual Occu	during most of works	ng 1	6b. Kind of Busin	ness/Industry
	121	within ene. than '	ompi	Elementary/Secondary (0-12) College (1-4or 5+)		DONOT use retire	*			
	<u>5</u>	e filed I Hygi other	e Cc	17. Father's Name (First, Middle, Last)		, , , , , , , , , , , , , , , , , , ,	18. Mother's Name	,		
1	ylar	ould by Menta Marked	ToE	JAMES A. ROE			<del></del>	Y LURI	-	
R	Maryland	d 2 sh th and 7 te m traum		19a. Informant's Name/Relationship (Type, Print)  MARY L. SHELLEY / MOTHER			at and Number or Rura		•	ate, Zip Code) AD 2/227
	<u>စ</u> ်	s 1 and f Heali ftem 2 other	- 8	20a. Method of Disposition 20	b. Place of Dist	position (Name of rematory or other pla			Oc. Location - Ci	
.0	E	Page nent o ant: If ary or		1X Burial 2 Gremation 3 Removal from State 4 Donation 5 Other (Specify)	DXFORD	CEMET	ERY 10-2	5-2005	OXFORE	PA 19363
1	Baltimore,	pernit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "retural" any injury or other traumatic event, the Madical Example.		21. Signature of Funeral Service Lidens		86 PIN	EST. O	XFORD,	PA 15	UNERAL HOME, INC.
_	*	Physician		23a. Part1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition		enter the mode of dy	ing, such as cardiac c	r respiratory arre	st,	Approximate Interval Between Onset and Death  CAM S.
		/Medical Examiner		resulting in death)  Due to (or as a con						1) 1000 2:
	*	LAMINIE	<u>_</u>	Sequentially list conditions, frany, leading to immediate b. Due to (or s a con						1) (14)
		d d anslt	Examiner	Cause. Disease or injury that initiated events c.	,					
	,8260,	cate be executed physician and the burial-transit	dical Exa	resulting in death) Last Due to (or as a con	sequence of):					
_	687		Medic	0.						
ORA	O. Box	Physician: The law requires that the death certific tribs certificate has been signed by the attending pr rail director, page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown  23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	3 □Ectopic pregnan 5 □ Other (specify)	су		23d. Date of Month	of delivery Day Year
AND	۵.	s that the ned by detac	y Ph	Part II. Other significant conditions contributing to death but not	resulting in the	underlying cause g	iven in Part I.	23e. Did toba	acco use contribu	ite to the cause of death?
4	rds	v requires ( been signe should be		Mental Ketandation	١,			1 ☐ Yes	2 No 3	Probably 4 Unknown
~ (	Recor	e law re has be ge 2 sho	Completed	Anxiety				24a. Was an autopsy	24b. We	re autopsy findings available r to completion of cause of th?
12	<u>=</u>	ian: The la rtificate ha stor, page 3		Serve					No 1	tn? Yes 2□ No
0	Ę	s certif	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient	2 - ER/Outpati	ient 3□ DOA O	26. Place of Death	me 5 ☐ Resider		(Snacihi)
( ~	n of	Jing Physician:  After this certific funeral director,	J: LC	27. Manner of Deth 28a. Dete of Injury 1 Natural 5 □ Pending (Month, Day Yea.	28b. Time	of 28c. Inju		28d. Describe how		Орасину
	Division	att :: e	catle	2 Accident investigation		M 1	]Yes 2□No	201   1   1   1   1		
	Σ.	after of Direction by	Certification:	4 Homicide determined 28e. Place of Injury - A building, etc. (Sp	At nome, farm, s secify)	street, factory, office		City or Town,	State)	or Rural Route Number,
,		To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by tt	Medical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the bast of my 2 Medical Exeminer: On the basis of examand manner stated.	knowledge, de nination and/or	ath occurred at the investigation, in my	time, date and place, opinion, death occurr	and due to the car ed at the time, da	use(s) and mann le and place, and	er as stated. I due to the cause(s)
		To the within 2 To the comple	Me	29b. Signature and title of certifier			nse number	29	d. Date signed (f	Month, Day, Year)
	)			> The Sylvin MASION MI),		19	676ko		11/01/05	5
		4		30. Name and address of person who completed cause of death (			BALTIM	ore Mi	). 2127	P.
		Sta Regista	ate rar	31. Date filed (Month, Day, Year)  32. Registrar's S  NOV 0 1 2005	ignature	W				

			State of Maryland / State Registrer		artment of He			ene 2005	35226
	Physicia		1. Decedent's Name (First, Middle, Last)  Charles Rockwell				2. Date of Death Month October	28, 2005	3. Time of Death 9:30 AM
	/Medic Examin	al	Charles Rockwell  4a. Facility Name (If not institution, give street and number)  Future Care Charles Village		4b. City, Town, or L	ocation of Death		4c. County of Dea	
	Funeral Director	And the second	5. Social Security Number 215−26−9397 6. Sex 1	birthday) Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, SEP 28,	Year) 9. Bir	thplace (State or Foreign ountry) St Virginia
	yland now		Usual Residence of Decedent           10a. State         10b. County         10c. City, To	own or Lo	cation				10d. Inside City Limits
	Ba-fst	ctor		altin					1 XYes 2 □ No
	with the	Funeral Director	901 N. Linwood Avenue		10f. Zip Code 212	05	10	g. Citizen of What Co USA	ountry?
	death	nera	11. Marital Status 12. Was Decedent Ever in U.S. Amped Forces?	13. \	Was Decedent of Hisp Yes, specify Cuban,		pecify Yes or No-	14. Race - Ami Black, Whi	
920	72 hours after death with the Maryland natural; or Iteme 23a or 28a-f show Jical Examinat must be notified at	by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 XNo		o moan, otc.,		White
21215-0036	J within 72 hours after death with the Marylan jiene. Than "natural!" or lieme 23a or 28a-1 show Lie Marijon Exantine must be notified at	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. L	lent's Usual Occupati kind of work done dui DO NOT use retired)	on ring most of wor	king	6b. Kind of Business	
d 21	Hyge III	e Co	17. Father's Name (First, Middle, Last)	Macm	nist 1	8. Mother's Nar	ne (First, Middle, M		ufacturing
Maryland	Mental Mental arked c	To B	Charles Edward Rockwell, Sr.			Myrtle	Twigge		
Mary	s 1 and 2 should Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)		g Address (Street an			500	econor 1
	s 1 and if Health item 27 other t		20a Mathed of Disposition 20b. Place	of Dispo	N. Church	Street	Morrist Date 2	OWIL TN 3 0c. Location - City or	7814 Town, State
mo	0 = 0				matory or other place) ematory, I	nc. 10/	29/05	Baltimon	ce, MD
Baltimore,	permit. Pag Department Important: sny injury once.		Dawn F. McDonald	22	remation 299 Freder	Society ick Road	of Maryl	and, Inc.	1228
	1 (%) 		23a. Part1. Enter the disease, or complications that caused the death. It shock, or heart failure. List only one cause on each line.	o not ent	er the mode of dying,	such as cardiad	or respiratory arre	st,	Approximate Interval Between Onset and Death
30	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence)	ce/of):	Mollit	CUIL	wetas	Tasis	
+	, 60 · 4	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ce of):	roular	1	710.	<del></del>	
	be executed sicien and burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last c	ce of):					
8760,	ite be ex lysicien he burial	cal	d						
9	ertifica ding ph	Med	IF FEMALE: 23c. If yes, outcome of pregnancy						
.O. Box	at the death certificate be executed by the attending physicien and tached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1	ath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
s, P	uires that t signed by Id be deta	ρ	Part II. Other significant conditions contributing to death but not resulting	g in the u	nderlying cause given	in Part I.			o the cause of death? robably 4 □Unknown
Record	The law requires that the sete has been signed by the page 2 should be detache	Completed					24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
Vital		Be	25. Was case referred to medical examiner?				ath (Check only one		
of \	Phyer this ral dii	2	1	Outpatier  b. Time of		4 My Nursing F	lome 5 Resider	nce 6 Other (Spe	ecify)
	Attending Fird death.	atlon	27. Manner of Death  1 Kantural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)	Injury	28c. Injury a Work?	s 2 🗆 No		. ,	
Division	5 # 5 ⊆	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, str	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medicai (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowler and manner on the basis of examination and manner stated.		vestigation, in my opin	nion, death occu			
)	with To t	Σ	29b. Signature and title of certifier and 11 compared to the signature and 11 compared to the signa	12		803	-	d. Date signed (Mon $28/$	Day, Year)
1			30. Name and address of person who completed cause of death (Item 23 )  31. Date filed (Month, Day, Year)  32. Redistrar's Signature (NOV 0 1 2005)	a) (Type,	I and	m	BORA	monde	746176
	Sta Registi		31. Date filed (Month, Day, Year)  NOV 0 1 2005	1 1	fauli		(		

			4 101	epartment of Health and Mental Hygie	2005 35227
				Certificate of Death Rag	No.
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Redmond	Month	Day Year 5.15 A M
	/Medic Examin	4	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	28 2605 5 15 AM  4c. County of Death
	LXaIIIII	C1	4308 CORTEZ RD.		ANNE ARUNDEL
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	hday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth	9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	(rs. OCT 18,	1930 MARYLAND
	ow other		10a. State 10b. County 10c. City, Town	or Location	10d. Inside City Limits
	Mary B-f sh	tor	MD. ANNE ARUNDEL BRO	OKLYN PARK	1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number		. Citizen of What Country?
	ath w		4308 CORTEZ RD.	21225	USA
	ltams	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Press 2 Nover Married 2 Married	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
936	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28a-f show to Mudical Erial in er must be coeffied at	þ	3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify: WHITE
21215-0036	72 hornatur	Completed	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of working	b. Kind of Business/Industry
2	vithin ne. han "	mple	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	EDAGE.
	filed w Hygiei othar ti		17. Father's Name (First, Middle, Last)	SALES De 18. Mother's Name (First, Middle, Ma	EPARTMENT STORE
and	id be 1 ental I ked o	To Be		DMOND HILDA	SCHAFER
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If item 27 Is marked other than "natural", or Items 23e or 28e-f show or other traumatic avant, It a Medical Ever in erroral ke rolling and or other traumatic avant.	F		Mailing Address (Street and Number or Rural Route Number, C	
-	and 2 salth a n 27 ls		JAY R REDMOND, SON 20		ISADENA MD 21122
Baltimore	of He of He if itan		1 Buriel 2 Branchise 2 Demouslifrom State Cemetery	r, crematory or other place)	c. Location - City or Town, State
Ë	nit. Pag partment oortant: 'injury o		'4 □Donation 5 □ Other (Specify) BAYVIE	W CREMATORY 10/29/05 B	ALTIMORE MD.
Bal	permit. Pages 'Department of h Important: If ite any injury or of		21. Signature of Funeral Service Licensee		UNERAL SERVKE P.A.
			23a, Parl . Enter the disease or complications that caused the death. Do n	4001 RITCHIE HWY. By ot enter the mode of dying, such as cardiac or respiratory arrest	Approximate
	Pnysician		Immediate Cause (Final	MA DECOLOR	Interval Between
	/Medical		disease or condition resulting in death)  Due to (or as a consequence of the control of the cont	f):	1 / 1/1/1
	Examiner		Sequentially list conditions, b.		
1	sit ad	iner	cause. Enter Underlying	ŋ:	
ζ_	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of	n:	
760,	s be essician	calE			
9	ificate g phy as the		U.		
Вох	death certificat e attending phy od for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 ☐Ectopic pregnancy	23d. Date of delivery
	0 0 0	sicis	in the past 12 months?  1  Yes 2 No 9  Unknown	5 Other (specify)	Month Day Year
P.O.	hat th od by i		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I 23e. Did tohar	co use contribute to the cause of death?
Records,	uires tha signed I d be det	d by	DIABETES MELLIT	U.S. 1 Yes	2 No 3 Probably 4 Unknown
cor	w requir been si should	lete	FCCENTIAL HYDER	TENCION 24a. Was an	24b. Were autopsy findings available
Re	The law requires that the ate has been signed by the page 2 should be detache	Completed		autopsy performe	prior to completion of cause of death?
of Vital		Be C	25. Was case referred a medical	1 ☐ Yes 2 M 26. Place of Death (Check only prie)	110 12 163 22 140
f V	ys dis	ToE	examiner?  1   Yes   No		e 6 □Other (Specify)
n c	ding Ph th. After th funeral	ion:	Taratalar o Training	ijury Work?	injury occurred
Division	Attending It death. actor: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, far	M 1 ☐ Yes 2 ☐ No	at and Number or Rural Route Number,
Οį	of or Attend after death Diractor: , d in by the f	Certification:	4 Homicide determined building, etc. (Specify)	City or Town, S	
	To the Hospital or Atten within 24 hours after deatl To the Funaral Director: completely filled in by the		29a. Certifier  (Check only (C	death occurred at the time, date and place, and due to the caus	e(s) and manner as stated.
	tha Hin 24 tha Fu	Medical	and manner stated.	Vor investigation, in my opinion, death occurred at the time, date	
	To To	2	29b. Signature Ingrille Signature Ingrille	29c. License rumber 60 007	Date signed (Month, Day, Year)
,	1				10LX 2002003
	1		30 Mam And a dre is of person who completed class (of death (Item 29a)	Tigo Print) SELO-HASSITCHI	EHIGHWAI
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	MITH THAT	D21225.
L	Registr	ar	NOV 0 1 2005	Sports	
DH	MH 17 Rev 1/2	001	NUV U I LOGO		

ORIGINAL

		,	1 - For State Registrar	State of M	aryland	/ Depa	rtment of H	lealth a D <i>eath</i>	and Me		ene	005	3522	8
	Physici		1. Decedent's Name (First, Middle, Last) Evelyn Jane Redm							Date of Death Month October	Day	Year 2005	3. Time of Death 2:00 P	h M
	/Medic Examir		4a. Facility Name (If not institution, give s The Wesley Home	street and number	7)		4b. City, Town, or Baltin		of Death		4c. Co	unty of Death		
	Funeral Director		5. Social Security Number 6. Sex 215-28-6858	7. A	ge (In yrs. las 87		If Under 1 Year Months Days	If Under Hours	Min.	Date of Birth (Month, Day, April 2	Year) 4,19	9. Birth Cou 18 Mary	place (State or Fore ntry) 1and	эign
	Maryland a-f ehow	tor	10a. State 10b. County  Maryland N/A		10c. City, 1	Town or Lo							10d. Inside City Lim	
	h with the	al Direc	10e. Street and Number The Wesley Home 2	211 W. F	Rogers	Ave.	10f. Zip Code	2	1209	10	g. Citizen	of What Cou	usa	
36	irs after deat	by Funeral Director	11. Marital Status  1 Never Married 2 Married  **X** Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Yes X2 If Yes, Give Year or Dates	? No	1	Vas Decedent of H Yes, specify Cuba □ Yes ¾M No	ispanic Ori in, Mexican Specify:	gin? (Specr ), Puerto Rid	fy Yes or No- can, etc.)		Race - Ameri Black, White, ecify: V		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Iteme 23e or 28e-f ehow appringury or other treumette event, the Medical Examiner must be maillist at an ance.	Completed	15. Decedent's Educition only highest grade  Elementary/Secondary (0-12)  12	ation		(Give . life. [	ent's Usual Occupa kind of work done of OO NOT use retired Homemake	during mosi ()	t of working	1		of Business/In		
land 2	uld be filed Mental Hygis Irked other Itfc event, I	To Be Co	17. Father's Name (First, Middle, Last) William Lawrence W	iles				18. Mothe		First, Middle, M Jane K	aiden Sui			
Mary	alth and I		19a. Informant's Name/Relationship (Type Mary Jane Redmond	-	ughter		g Address (Street a 7 Landman							
Baltimore,	Pages 1 a nent of He ant: if Item ury or othe		20a. Method of Disposition  1 △ Surial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	emoval from State	St.	e of Dispos etery, crep Mary	sition (Name of patory or other places Cemete)	<i>ө)</i>	Dat 11/1/2			on-City or To len, Ma		
Balt	Departition Departition Import		21. Signature of Funeral Service License	iputin		B 3	Name and Alres UISE - TIII 631 Falls	s of Facilit 1SS-S KOA	itz I I Bal	Tuneral Limore	Home MD	11211.		
)	Physician /Medical		23a. amt. Enter the stease, or complies shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	END	STA	Do not ente		g, such as	cardiac or r				Approximate Interval Between Onset and Death	
	cate be executed by sician and by sician and ithe burial-transit and	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	s a consequent of the second o	CULA nce of): LTERIO	R DI. Scienon	SEAS C		ASCULA	2 D	IJen Se	YEARS YEARS	
	Physicien: The law requires that the death certificat this certificate has been signed by the attending phyral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcom 1 Live birth 4 Pregnant	2 Fetal de	ath 3	Ectopic pregnancy Other (specify)				23d.	Date of delive	ery Day Year	
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions con	tributing to death	but not resultin	ng in the un	derlying cause give	en in Part I.			1000 use o		ne cause of death?	
Vital Record	Physicien: The law requ r this certificate has been rral director, page 2 shouli	Completed								24a. Was an autopsy perform		4b. Were auto prior to co death? 1  Yes	psy findings availal apletion of cause of	ble of
Zita Zita	s certifi lirector	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 ☐ Inpat	ient 20E0	VOutpatient	3□ DOA Othe			Check only one		Oth / C /		_
Division of	To the Hospital or Attending Phy within 24 hours attended the To the Funerel Director: After this completely filled in by the funeral or		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, D	ury 28	Bb. Time of Injury	28c. Injury Work	-	280	d. Describe hov			//	
DİXİ	To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, e	tc. (Specify)		et, factory, office		1	City or Town,	State)		l Route Number,	
	ne Hospita n 24 hours ne Funerel	edical	29a. Certifier (Check only one)  Certifying Physical Examination	ician: To the bes ar: On the basis and manners	or examination	dge, death and/or inv	occurred at the time estigation, in my op	e, date and pinion, deat	d place, and th occurred	d due to the cau at the time, dat	ise(s) and e and pla	manner as s ce, and due to	ated. the cause(s)	
	To the To the complet	M	29b. Signature and title of certifier	olyn	P.		29c. License	number 1942	5	29	d. Date, signature $\frac{10}{3}$	gned (Month,	Day, Year)	
	3		30. Name and address of person who con	mpleted cause of	death (Item 23	Ba) (Type, F	erint)	AVE	BAL	70 MD	. 2	1209		
	Sta Registr		31. Date filed (Month, Day, Year)  NOV 0 1 200		trar's Signatura	Los	the	7						

DHMH 17 Rev 1/2001

EXFIRE 10/29/05 @ 2 pm

RED MOND

			For	State of Man		artment of Heal		giene OOF	25220
			1 - Stata Registrar		Cei	rtificate of Dea	ath <sub>F</sub>	Reg. No. UUJ	35229
	Physici	an	Decedent's Name (First, Middle, La	st)			2. Date of Dea Month	ath Day Year	3. Time of Death
	/Medic		Susan Baile	-	chards		October	30 2005	8:22 A M
	Examin	er	4a. Facility Name (If not institution, giv		-	4b. Cily, Town, or Loca		4c. County of Dea	
			Shady Grove Advention 5. Social Security Number 6. S		a⊥ In yrs. last birthday)	Rockville		Montgome	
	Funeral Director			THE OFFICE	58 Yrs.		urs Min. 8. Date of Birth (Month, Day March 22	, Year) , 1947 01	rthplace (State or Foreign country) hio
	land ow		10a. State 10b. County	11	Oc. City, Town or Lo	cation			10d. Inside City Limits
	Many Fe sh	tor	Maryland Montgome	rv	Gaither	churo			1 ☐ Yes 2X No
	th the or 284 e not	Director	10e. Street and Number		00101101	10f. Zip Code		10g. Citizen of What C	ountry?
	th wi	ai C	15485 Peach Leaf	Lane		20878		USA	
	r dea	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of Hispani f Yes, specify Cuban, Me	ic Origin? (Specify Yes or No- oxican, Puerto Rican, etc.)	14. Race - Am Black, Whi	
36	s afte , or it	by Fu	1 ☐ Never Married 2 ☑ Marned 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give		1 ☐ Yes 2 No Spe		Specify:	
8	72 hours after death with the Maryland natural', or items 23a or 28a-f show dical Exattural must be notified at	ed b	15. Decedent's Eq	Year or Dates:	16a Dacar	dent's Usual Occupation		wn	ite
15	in 72 n "na	piet	(Specify only highest gra	ade completed)	(Give	kind of work done during DO NOT use retired)	most of working	16b. Kind of Business	vindustry
21215-0036	d within giene. rr than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	He	omemaker		Own Home	
	be filed within 72 hours after death with the Marylan ital Hygiene. Indoorder than "natural", or items 23a or 28a-f show event, the Madical Exertainer must be notified at	Be C	17. Father's Name (First, Middle, Last)	)		18. A	Mother's Name (First, Middle,	Maiden Sumame)	
Maryland	should be and Mental is marked c	To	Lewis Calvin	Bailey		Ed	ina Naomi	Mark	
lar			19a. Informant's Name/Relationship (				umber or Rural Route Number		
	s 1 and if Health item 27 other tr		John A. Richards/				Lane Gaithers		
Baltimore,	or High		20a. Method of Disposition 1   ■ Burial 2   □ Cremation 3   □	Removal from State	20b. Place of Dispo	natory or other place) St Side	November 5,	20c. Location - City or	
量	그 든 원 승	1	4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Licer		Cemete	ry	2005 M	onroe Twp.	, Ohio
Ba	Depariment of the parameter of the param		Down /	. 30 11	100798 Ro	ckville, Inc ckville, Mar	Facility Robert A.c. 300 West Mc Cyland 20850-2	ntgomery A 805	venue
п			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	e death. Do not ent	•	-	)	Approximate Interval Between
1 22	Physician		Immediate Cause (Final disease or condition resulting in death)	a Hou	Te My	OCAMPIA	2 INFARC	TON	Onset and Death M/NUTES
	/Medical Examiner		resulting in dealth	Due to (or as a co	onsequence of)	And	1 -		
9.5		er	Sequentially list conditions,	b Certan	UNITE				
	nsit		if any, leading to immediate	Due to (or as a co	onsequence of):	Jig cx g	disense		years
	3 5 6	mlm	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	onsequence of):	y a cx g	discipe		yems
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8760,	te be ysicie ie bui	cai	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c		yra cz g	diserse		yems
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	Examin Funeral		4a. Facility Name (If  Greater  5. Social Security Nu  219-32-	Baltin umber	ore	Medic	al C	yrs. last birtl	hday) (rs.	Towson If Under 1 Year Months Days	If Under 24 h		elite of Bi	В	altimo	re	tate or Foreign
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	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "neturel", or Items 23e or 28e-f show or other treumatic event, the Medical Erand er must be ricitlised at	Funeral Di	2117 SU		12	. Was Dece	rces?	in U.S.	13. \	Was Decedent of I	21209 Hispanic Origin? an, Mexican, Po	? (Speci uerto Ri	fy Yes or No	0-		USA merican India /hite, etc.	
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on or vital	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: Atter this certifics completely filled in by the funeral director,	atlon; To Be	25. Was case referrexaminer? 1  Yes 2 2 27. Manner of Death 1 Natural 2  Accident	No .		28a. Date	npatient of Injury th, Day Ye	2 ER/Out 28b. T ear)		28c. Inju		ng Home	5 □ Res	idence	6 ☐Other (Sury occurred	Specify)	
DIVISION	spitel or Atter ours after des nerel Director filled in by th	Certification:	3 Suicide 4 Homicide	6 Could r determi		28e. Place buildi	of Injury - ng, etc. (5	At home, far Specify)	rm, str	eet, factory, office		28	f. Location ( City or To		nd Number or e)	r Rural Route	Number,
	To the Hospi within 24 hou To the Funer completely fill	Medical	one)	2 Medicel I	g Physic	er: On the b	best of m asis of exa ner stated	amination and	, death d/or in	occurred at the ti vestigation, in my	opinion, death o	lace, an	d due to the at the time,	, date an	s) and manner of place, and ate signed (M	due to the ca	
	D		29b. Signature and	thia i		iam				Do	5134	17		10	1281	25	
	Sta	ato	30. Name and address CYNTN  31. Date filed (Mont	19 Soi	ial	NON	19	(Item 23a) ( 6 70 ) Signature	Type,	i Char	12151	B	altiv	nol	e MI	) 44	)4
**	Regist		NO	th, Day, Year)	2005	Best	460	St. St.	10	1							

State of Maryland / Department of Health and Mental Hygiere 05 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** ARVIN ROSEN Oct 2005 2:26 28 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MEDILAL CENTER BALTIMORE MERCY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 □ F **Funeral** Days Hours Min. Director 212-50-5405 57 JAN.4,1948 MD Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County **ehow** ir then "neturel", or items 23a or 28a-f ehov the Madical Examiner must be notified at 1 ☐ Yes 2 No Directo BALTIMORE BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14 HURLINGHAM COURT 21208 Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or item eny injury or other treumatic event, the Medical Examinations. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ATTORNEY LAW 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SVIDGALL ROSEN DEVERA **JOSEPH** ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14 HURLINGHAM COURT - BALTIMORE, MD 21208 SHEILA ROSEN / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State MOSES MONTEFIORE CEM 10/30/2005 HALETHORPE, MD 4 Don tio 5 Other (Specify) of Fineral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signal 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Nonhodalcus CHUDHOMA /Medical Due to (or as a onsequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Exam Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4□Pregnant at time of death s been signed be stated by should be detailed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate hes to certificate 1 Yes 2 No To the Hospitel or Attending Physician: 25. Was case referred to medical Be 26. Place of Death Check only one examiner Other: ပို 1 Yes 2 No 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending 1 Tes 2 No investigation Il Director: / 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire Learnitying Physician: To the best of my knowledge death occurred at the time, date and place and due to the cause(s) and manher as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 25x Certific Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P17678 28,2005 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St Paul Street Balhmore, MD 21202 Blome 301 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MARKE 0 Miller Registrar

			1 - State State Registrar		artment of Health and <i>rtificate of Death</i>	Mental Hygier	2000 30232
			Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
	Physici /Medio		WILLIE M	AE ST	OWE		29 2005 11:00 AM
	Examin		4a. Facility Name (If not institution, give street and GOOD SAMAILITAN HO)		4b. City, Town, or Location of Dec	ath	4c. County of Death
	Funeral Director		5. Social Security Number  243-48-5270  G. Sex 1□ M 2  G. Weight Service Serv	7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hi   Months   Days   Hours   Min		9. Birthplace (State or Foreign Country) 19:33 NOR THE CARELINA
	yland now		10a. State 10b. County	10c. City, Town or Le	ocation	0	10d. Inside City Limits
	Be-1 s	Funeral Director	MARYLAND N/A			IORE CI	Ty 12Yes 2 No
	with th	Dir	10e. Street and Number	2000 #100	10f. Zip Code	10g. (	Citizen of What Country?
	death	nera	11. Marital Status 12. Was D	ecedent Ever in U.S. 13. Forces?	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - American Indian, Black, White, etc.
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "neturel", or items 23s or 28e-1 show other treumetic event, the Medical Experiment mast be rediffied at	by Fu	1 Never Married 2 Married 1 Yes,	s 2 X No	1 ☐ Yes 2 🗖 No Specify:	nto riidan, bio.j	Specify: BI AO II
5-0036	2 hour	ted t	15. Decedent's Education	16a. Dece	dent's Usual Occupation a kind of work done during most of w	16b.	Kind of Business/Industry
21	within 7 iene.	Completed	(Specify only highest grade complete Elementary/Secondary (0-12)  College		DO NOT use retired)		to any no a Herrica
d 21	i filed v I Hygie other t	Be Co	17. Father's Name (First, Middle, Last)		NURSE 18. Mother's N	ame (First, Middle, Maid	PARRISBURG HOSPITAL
Maryland	should be and Mental Is marked o	To B	FARRIS	EARL	LUL	.A	WILSON
Mar	d 2 sho		19a. Informant's Name/Relationship (Type, Print)	7	ing Address (Street and Number or I	6	
	s 1 and f Health Item 27 other tr		20a. Method of Disposition	AUGITTER) 5 6 20b. Place of Dispo	osition (Name of matory or other place)		BALTO, MO. 21215 Location · City or Town, State
imo	Page nent o ent: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fro `4 ☐ Donation 5 ☐ Other (Specify)	m State  MCTRO	CREMATORY 11-	01-05 B	ALTIMORE MARYLAND
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licensee	Villiams?	2. Name and Address of acility  JOSEPHH.  2140 N. F-ULT	BROWN JR	ALTIMORE, MAKYLAND FUNERAL HOME BALTO, MD. 21217
	#		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the death. Do not en n each line.			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	SEPSIS			Onset and Double
B	Examiner			to (or as a consequence of):	facation		
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8760,	cate be executed physician and the burial-transit	dicai	d				
9		/Med	IF FEMALE: 23c If yes	outcome of pregnancy			001 Dub 4/4 F
P.O. Box	at the death certific by the attending partected for use as	Physician/Me	in the pact 12 months?	re birth 2 Fetal death 3 [ egnant at time of death 5 [	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery  Month Day Year
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Vita	Phyeicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 \sum Yes 2 \sum No Hospital: 1	Minpatient 2 ☐ ER/Outpatie		eath (Check only one)	
	ding Phyo h. After this funeral di	<b>-</b>	27. Manner of Death 28a. Da	te of Injury fonth, Day Year)  28b. Time of Injury		Home 5 Residence	
sior	tendin eath. or: Aft the fun	catio	2 Accident investigation	onn, bay reary injury	M 1 Yes 2 No		
Division	el or Att s after d il Direct	Certification;	determined 288. Pla	ace of Injury · At home, farm, st ilding, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospitel or Attending i within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Medicai (	(Check only 2 Medical Examiner: On the	the best of my knowledge, deat e basis of examination and/or in anner stated.	th occurred at the time, date and plan estigation, in my opinion, death occ	ce, and due to the cause curred at the time, date a	(s) and manner as stated. ind place, and due to the cause(s)
)	To ti withi To ti comp	Ň	29b. Signature and title of certified Saghti		29c. License number	01 00	Date signed (Month, Day, Year) Abber 29th - 2505
4			30. Name and address of person who completed of SALIM RAGHLI 50	ause of death (Item 23a) (Type,		RALTIMOR -	HOSPITAL MD-C1239
	Stá		31. Date filed (Month, Day, Year) 32	. Registrar's Signature	1 - 4 -		
	Regist	ai	NOV 0 1 2005	Allegia De A	Some		

		1- State of Mar Registrar	ryland / Depa <i>Cel</i>	artment of Health	and Mental Hy h	/gieme 005	35233
Physic		Decedent's Name (First, Middle, Last)     Mark Eugene Smelser	· · · · · · · · · · · · · · · · · · ·	4	2. Date of De Month		3. Time of Death S Z 39 AM
/Medi Exami		4a. Facility Name (If not institution, give street and number) Union Memorial Hospital		4b. City, Town, or Location Baltimore	n of Death	4c. County of De	ath
Funeral Director		*	(In yrs. last birthday) 61 Yrs.		er 24 Hrs. 8. Date of Bi	av. Year)	A inthplace (State or Foreign Country) MD
yland		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
he Mar 8a-f et	ector	MD N/A	Baltimore				1 X Yes 2 □ No
h with t	ai Dir	4100 Roland Avenue, Second	floor	10f. Zip Code 21211		10g. Citizen of What C	Country?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or items 23a or 28a-f show any Injury or other traumatic event. Its Modical Examination and its motified at points.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Marned  3 □ Widowed 4 1 □ Divorced  12. Was Decedent Every Armed Forces?  1 □ Yes 2 □ No II Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent of Hispanic Clif Yes, specify Cuban, Mexic		14. Race - Am Black, Wh	
21215-0036  Id within 72 hours aft giene.  In then "neturel; or I the Medical Exerci-	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during mo DO NOT use retired)	ost of working	16b. Kind of Busines	
2121 d within giene. rrthen	ошо	Elementary/Secondary (0-12) College (1-4or 5+)	1	DO NOT use retired)  Lance Artist		Fine Ar	ts
ind to the filed of the went.	Be	17. Father's Name (First, Middle, Last)			ther's Name (First, Middle	, Maiden Sumame)	
Maryland of 2 should be file lih and Mental Hy 27 Is marked oth rtraumatic event	5	Irvin Eugene Smelser  19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Num		Oavis	Zin Code)
and 2 salth ar n 27 ls		Mary M. Davis - mother	4100	Roland Ave.,			
ages 1 nt of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	i	esition (Name of matory or other place)	Date	20c. Location - City o	
Baltimore, crimit. Pages 1 ar Department of Hea mportant: If item into Injury or other		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee		Crematory Inc AFA, Stephen		Beltsvil	le, MD
Depa Depa Impo			100000	71/ Green Pas	stures Drive	. Towson. I	D 21286
Division		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	ne death. Do not ent	er the mode of dying, such a	as cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	consequence of):	bled			
Examiner	Į.	Sequentially list conditions, if any, leading to immediate	hol al	ouse			21012
cuted	Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events	55.1004001100 071				
ficate be executed physicien and is the burial-transit	ai Exa		consequence of):				
687 tificate ig phys as the	ledicai	d					
Records, P.O. Box 6 The law requires that the death certifi ate has been signed by the attending, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of de Month	olivery Day Year
S, P	by Ph	Part II. Other significant conditions contributing to death but	not resulting in the ur	nderlying cause given in Part	t I. 23e. Did t	obacco use contribute t	o the cause of death?
cord w require been sig	eted				10'	Yes 2€700 3□P	robably 4 Unknown
Records, he law requires the has been signe	Completed				24a. Was autop	psy prior to death?	utopsy findings available completion of cause of
on of Vital Reding Physician: The Atler this certificate his funeral director, page	Be Co	25. Was case referred to medical examiner?		26. Plac	1 ☐ Yes	2 <b>200 h</b> 1 □ Yesone)	s 2000
Vision of Vita Attending Physicien: r death. ector: After this certifica by the funeral director.	P	1 Yes 2 Aanna atient  27. Manner of Death  28a. Date of Injury			Nursing Home 5 Resid		ecify)
ion nding l ath. r: After e funer	ation	1 At Satural 5 Pending (Month, Day) 2 Accident investigation	/ear) 28b. Time of Injury	28c. Injury at Work?  M 1 Yes 2		how injury occurred	
Division of Vital lal or Attending Physician: 7 s after death. al Director: After this certificat ed in by the funeral director, p	Certification;	3 Could not be	/ - At home, farm, stre (Specify)	eet, factory, office	28f. Location ( City or To	Street and Number or R wn, State)	ural Route Number,
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edicai	29a. Certifier (Clisck off) and manner state	xamination and/or inv	n occurred at the time, date a vestigation, in my opinion, de	and place, and due to the eath occurred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
To To Con	M	29b. Signature and title of certifier  M.D.		ATZ438	946-F3	29d. Date signed (Mon.	
5 Str	ato.	30. Name and address of person who completed cause of dea RHJA HGINUL NOR MG  31. Date filed (Month, Day, Year) 32 Registrars	Ú	NION MEMO	RIAL HOSE	PITAL M	7
Regist		NOV 0 1 2005	R R	AF O			
DHMH 17 Rev 1/2	001		ORIGIN	VAL			

			1 - For State Registrar	State of M	faryland / De <i>C</i>	partment e <i>rtificate</i>	of Health a of Death	and Me	ental Hyg	giene	005	35234
ı			1. Decedent's Name (First, Middle, La	st)				2	2. Date of Dea Month	ith Day	Year	3. Time of Death
`	Physici /Medic		Wilford Earl	Schmidt					October	30	2005	5:30 p M
	Examir		4a. Fecility Name (If not institution, give		r)		own, or Location of	of Death			County of Deal	th
			HCR Manor Care T  5. Social Security Number 6.3		ige (In yrs. last birthda		VSON	24 Hrs.   6	Date of Birth		wson	thplece (State or Foreign
	Funeral Director			103M 2□F	80 Yrs.	Months	Days Hours	Min.	3. Date of Birth Month, Day OCT 25	1925	5	ountry) MD
			Usual Residence of Decedent									
	arylar show	<u>_</u>	10a. State 10b. County		10c. City, Town or							10d. Inside City Limits 1 ☐ Yes 2X No
	889-f	Director	MD Baltim	ore	Timoni					10- 031-		
	with a or 3	Ö	10e. Street and Number 32 Edgemoor Road			10f. Zip 0	21093			iog. Citize	en of What Co USA	ountry?
	Jeath The 23	Funeral	11. Marital Status	12. Was Deceden	at Ever in U.S. 1		int of Hispanic Ori	gin? (Speci	ify Yes or No-	14	4. Race - Ame	erican Indian,
0	or Ital		1 Never Married 2 Married	Armed Forces 1 Yes 2 2 If Yes, Give	i? ¶No	If Yes, specif		n, Puerto Ri	ican, etc.)		Black, Whit	
2-0030	ural',	d by	3 ☐ Widowed 4 1 Divorced	Year or Dates	:	TO THE Z	23 NO Specify:				Specify:	white
ה ה	n 72 h	Completed	15. Decedent's E (Specify only highest gr		(G	cedent's Usual ve kind of work ). DO NOT use	done during most	t of working	,	16b. Kind	d of Business/	Industry
7	withir	фщо	Elementary/Secondary (0-12)	College (1-4or	r 5+)	lanager	, retired)				Pharma	cv
2	i Hyg other	Be C	17. Father's Name (First, Middle, Last			<u> </u>	18. Mothe		First, Middle,			- )
/land	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or Itams 23s or 28e-f show eumatic event, the Medical Evernment must be nutified at	To B	John Schmidt				Anr	na I	Ludwig			
2	ロミトン		19a. Informant's Name/Relationship Donna Gillespie	<sup>Турө, Print)</sup> - daughte	r 32	illing Address ( Edgemod	Street and Number or Road,	r or Rural I Timor	nium, M	r, City or 1	Town, State, 2 1093	Zip Code)
re,	of Health Item 27		20a. Method of Disposition	TD	20b. Place of Dis	position (Name rematory or oth	e of ner place)	Da	te	20c. Loca	ation - City or	Town, State
Ě	Page ment ant: H		1 ☐ Burial 2 🏻 Cremation 3 ☐  `4 ☐ Donation 5 ☐ Other (Speci		Chesapeak	e Cremato	ory Inc 1	1/01/	/2005	Bel	tsvill	e, MD
baitimor	permil. Pages 1 and Department of Heali Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Lice	1 14	00986	CAFA, and 8717 Gr	Address of Facility tephen L een Past	). Lot	nrmann, Drive.	PA Tow	son. M	D 21286
r			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	ed the death. Do not				-			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		-0	concer						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequence of):							
	- Zummer	<u></u>	Sequentially list conditions,	b. — Due to (or a	s a consequence of):							
V	nsit	in in	if any, leading to immediate cause. Enter Underlying	540 (5) 4	is a consequence on,							
	execu in and ial-tra	Examine	that initiated events resulting in death) Last	Due to (or a	s a consequence of):							
6/60,	death certificate be executed e attending physician and d for use as the burial-transit	dicai		_ d					·			
Ō	artifica ing ph e as th	Med	IF FEMALE:		100							
ZOD	w requires that the death certific been signed by the attending p should be detached for use as	hysician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic pre				23	ld. Date of del	ivery Day Year
	he de	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐ Pregnant : 9☐ Unknown	at time of death	5 Other (spec	city)					
Ţ.	requires that the	0	Part II. Other significant conditions	contributing to death	but not resulting in the	underlying cau	use given in Part !.		23e. Did to	bacco use	e contribute to	the cause of death?
	quires n sign	ed by							1 🗆 Y	es 28	No 3□Pr	obably 4 Unknown
ecord	law ren as bee 2 shoi	ompleted							24a. Was a		24b. Were au	topsy findings available
r	The law ate has b page 2 st	E							autops perform	med?	death?	completion of cause of
VIEBI	ysician: The lis certificate hadirector, page	BeC	25. Was case referred to medical examiner?						Check only on	10)		
_		ို	1 ☐ Yes 2 ☑No	Hospital: 1 ☐ Inpat			_					cify)
	After I	ion:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of In (Month, D	jury 28b. Time Jay Year) Injur	of 28	c. Injury at Work?		d. Describe ho	ow injury (	occurred	
DIVISION	death ctor: ,	lcat	2 Accident investigation 3 Suicide 6 Could not be	De Glace of Is	njury - At home, farm,		1 Yes 2 1		f. Location (Si	treet and i	Number or Ri	ıral Route Number,
2	al or A after i Direct	Certification:	4 Homicide determined	building,	atc. (Specify)	Street, ractory,	omos	1	City or Town		770	nar riodio redinidor,
	To the Hospital or Attending Phywithin 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	edical C	29a. Certifier 1 Certifying P. (Check only one)	hysician: To the bes miner: On the basis and manner:	st of my knowledge, de of examination and/or stated.	ath occurred at investigation, in	t the time, date and n my opinion, dee	d place, an th occurred	d due to the c	ause(s) ar	nd manner as lace, and due	stated. to the cause(s)
	ro the vithin To the comple	Med	29b. Signature and title of certifier	Sing manings		29c.	License number		2	9d. Date	signed (Montl	h, Day, Year)
	,- > = 0		I mien-1	you KIT	y		03/86			10	-3/-	05
	Λ				1	e, Print)						
	2		416 E. jo	ma Ro	70	wson	m	d 2	1586			
	Sta Registi		31. Date filed (Month, Dey, Year)  NOV 0 1	2005 32. Regis	death (Item 23a) (Typer Treats Signature	Syster)						

State of Maryland / Department of Health and Mental Hygiene 05 35235 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Lorraine Spadaro 3:54 A M 05 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Point Rehab and Nursey Ct. Baltimore 21274 Baltunove Count If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7- Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 1 21228522 Director Maryland Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "neturel", or items 23a or 28e-f show treumatic event, Ite Madical Examiner must be mutilled at MD Director Baltimore 1 ☐ Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? XIII 7815 Wynbrook Road death by Funeral 21224 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 shoutd be filed within 72 hours after of and Mental Hygiene. Is marked othar then "neturel", or Itel 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4X Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Equitable Bank Teller 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jake L. Birdsong Bertha Gott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 st of Health ar If item 27 If Eleanor Smith /sister 7815 Wynbrook Road Baltimore MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Pages 1
Department of H
Important: If iter
eny injury or oth 20c. Location - City or Town, State 1 ☐ Burial 2XX remation 3 ☐ Removal from State Baltimore MD BayviewCrematory 10/29/05 \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licensee 30<u>0 Mace</u> Ave. Baltimore MD 21221 23a. Part1. Enter the disease, or compli-shock, or heart failure. List only on tions that caused the death. Deflot enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cronic obsme7 ummay diseas VRENS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any, loading to him orders cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transif Due to (or as a consequence of): Box 68760. attending physician Physiclan/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ preumonica 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Thursing Home 5 Residence 6 Other (Specify) ပ 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification; 28d. Describe how injury occurred : After Injury 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel I 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mua Book 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)\_ 5505 Hopkins Bayriew Civile 32. Pegistrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 1 2005 Registrar

		-:	For State Registrer	State of Marylar		artment of H		d Mental F	lygie Reg.	ZUUB	35236
-	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Month	Death	Day Yea	3. Time of Death
	/Medi		Sidney					OCT	27	2005	9:09a M
	Examir	er	4a. Facility Name (If not institution, give s			4b. City, Town, or		Death		4c. County of De	
***		N. O.	Montgomery General  5. Social Security Number 6. Sex		last hirthday)	OIne	If Under 24	Hrs. 8. Date of	Righ		gomery
	Funeral Director		130-22-4998	7. Age (In yrs.	Yrs.	Months Days		Min. (Month, JUN 6	Day, Ye	ear) (	inthplace (State or Foreign Country)
	70		Usual Residence of Decedent					JOIN O	, <u>1</u>	oro Ne	w York
	arylar ehow	-	10a. State 10b. County	10c. C	ity, Town or Lo	ocation					10d. Inside City Limits
	Me Mi	ecto	Maryland Montgome	ry	S	ilver Spr	ing		<del>,</del>		1 ☐ Yes 2XNo
	a or 2	Funeral Director	3701 Internation	nol Deire		10f. Zip Code	06		10g.	Citizen of What (	Country?
	leath	era		12. Was Decedent Ever in U	JS 13	209 Was Decedent of Hi		2 (Specify Ves or	No	USA 14. Race - An	norican Indian
10	ritan	Fun	1 Never Married 2 Married	Armed Forces? 1X Yes 2 □ No		f Yes, specify Cuba	n, Mexican, P	uerto Rican, etc.)	NO-	Black, Wh	
Ö	al', o	þ	3X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 <b>X</b> No	Specify:			Specify: W	hite
21215-0036	within 72 hours after death with the Maryland ene. then "netural", or Itams 23e or 28e-f ehow ite Mudical Evertiner must be notitied at	Completed	15. Decedent's Educ (Specify only highest grade	cation (completed)	16a. Dece	dent's Usual Occupa kind of work done d	ition	working	16b	. Kind of Busines	s/Industry
2	vithin ne.	mpk	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired,	) -	working			
	lled w tygie ther ti		17. Father's Name (First, Middle, Last)	5+		Physician		hi		iternal 1	Medicine
and	d be filled intal Hygi ed other	Be	Jacob Sbar					Name (First, Midd ie Lukas)			
Maryland	should nd Men marke umatic	2	19a. Informant's Name/Relationship (Typ	oe. Print)	19h Mailir	ng Address (Street a					Zin Codel
	and 2 sauth ar n 27 is er trau		Victoria Schor/da	•		Hillsboro					
ē,	s 1 ar		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of natory or other place		Date	200	ing, MD. Location - City of	or Town, State
E	Pages nent of int: if its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R. 4 ☐ Donation 5 ☐ Other (Specify)			ematory,		0/28/05	F	Baltimore	. MD
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural; or Itams 23s or 28a-f ehow with highry or other traumatic event, the Mucical Examinat must be notified at angle.		21. Signatur of uneral Service Uncense	Carrelal		Cremation					
<u> </u>	89 6 2 8		Dawn F. McDona	and Monce		299 Frede	rick Ro	oad Rali	∵imo	na, inc.	) 1222
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the deal e cause on each line.	th. Do not ent	er the mode of dying	, such as care	diac or respiratory	arrest,	<del></del>	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_Cardiac Arr	rest						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):					·	4 days
1 P		_	Sequentially list conditions, b	Myocardial		tion					
	ted	Examiner	i any, leaving to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence or):						
	al-tra	xar	that initiated events cresulting in death) Last	Due to (or as a consec	quence of):				-		
8760,	cate be executed physicien and the burial-transit	dicail									
9	tificat ng phy as th										
ŏ	th cer tendir r use	Physician/Me	250. Was decedent program	ac. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy				23d. Date of de	elivery
о. П	e dea he at	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at time of o		Other (specify)				Month	Day Year
P.O. Box	that the death certifised by the attending of detached for use as	Phy	9 ☐ Unknown  Part II. Other significant conditions con-								
Records,	se us	d by	Tattii. Other significant conditions con	moding to death but not res	sulling in the ur	loarlying causa give	n in Part I.		Tobacc ]Yes	_	to the cause of death?  Probably 4Unknown
Ö	w requir been s should	ete									
Re	The lav	Completed						24a. Wa	ODSV	prior to	utopsy findings available completion of cause of
ta	ilcian: Th certificate rector, pag	Ö	25. Was case referred to medical					per 1 🗆 Yes	7 77 77	No 1 ☐ Ye	s 2□No
>	Physician: this certificaral director, p	0 8	examiner?	ospital:	ER/Outpatien	Otho		Death <i>Check only</i> g Home 5 ☐ Re		6 Clother (Co.	(-)
		L.	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury Work		28d. Describe			эспу)
0	Attending ir death. ector: After by the fune	atic	1 XNatural 5 Pending 2 Accident investigation	(Month, Day 7 dai)	пцагу		es 2 □No				
Ž	after death after death Director: in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	eet, factory, office		28f. Location City or T	(Street	and Number or R	tural Route Number,
	ortal curs af									,	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) 1 Medical Examin	cien: To the best of my known: On the basis of examina	owledge, death ation and/or inv	occurred at the time estigation, in my opi	e, date and pla nion, death o	ace, and due to the ccurred at the time	e cause e, date a	(s) and manner a and place, and du	s stated. e to the cause(s)
	o the o the omple	Mec	29b Signature and title of certifier	and manner stated.		29c. License				Date signed (Mon	
	⊢s⊢ō					D006				LO/27/05	, way, . sui/
		1	30: Name and address of person who cor	npleted cause of death (Item	n 23a) (Type J						
0	75-67		Robert Kirkcal				<b>Поде</b>	L - 1			
	Sta	0 0	31 Date filed (Month Day Veer)	dy Montgor	ature	1263	<del>uvsp1</del> 1	t <del>d1 ()</del> 1	ney	, MD	
1 55	Registra	ar .	MOAGTE	The state of the s	2						

UNK

05-06568 RKD		Please 1  1- For Unpend Item 2 Registrar				a. Ensure Al lealth and M 18-05 tas Death	lental Hygi	_	35237
Physica /Media		Decedent's Name (First, Middle, Last     Barry Edward Sm					2. Date of Death Month SEPTEMB	Day Year	3. Time of Death  4:31P.
Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Death	DIA IL. III	4c. County of Dea	th
∞ 2	2.	1617 W.BALTIMORE S			BALTIN			N/A	
Funeral		5. Social Security Numberunk 6. Se	x 7. Ag 7. Ag 7. Ag	e (In yrs. last birthd	Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign ountry)
Director		Usual Residence of Decedent	7	43			Apr 9, 1	.962 Ma	ryland
yland		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
e Mar	ctor	MD		В	altimore				1 X Yes 2 □ No
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. other then "naturel", or iteme 23a or 28a-f ehow ent, the Medical Examination itselfied at	Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
e 23e	ral	1617 W. Baltimore				21223		USA	
ier de	E I	11. Marital Status  1    XNever Married 2   Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ XI		<ol> <li>Was Decedent of I If Yes, specify Cub</li> </ol>	Hispanic Origin? (Spe pan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
336 Irs aft	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	40	1 ☐ Yes 2 🔀 No	Specify:		Specify: b	Lack
15-003		15. Decedent's Edu		16a. De	cedent's Usual Occu	pation	10	6b. Kind of Business	Industry
Ind 21215-0 be filed within 72 ho ital Hygiene. id other then "natur event, the Medical	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completea) College (1-4or 5	life	ve kind of work done  DO NOT use retire	during most of workilled)	ng		
22 garage and the state of the	Con	9	0		laborer			construct	ion
be fill doth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		aiden Sumame)	
Y 2	2	Gene Lee Smith				Minnie Jo			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or any injury or other traumatic event, the Medical Exampance.		19a. Informant's Name/Relationship (T)				and Number or Rura			
G, C, Land 1 and Healt Healt their their	1	Rhonda Smith/sist	er		N. Luzern sposition (Name of	e Avenue E		e, MD 212 Oc. Location - City or	
nor ages and of the life if it is if it if it is it is if it is it is if it is it is if it is		1 ☐ Burial 2 ☐ Cremation 3 ☐ F	lemoval from State	cemetery, c	rematory or other pla	ce)	2.	oo. Lood lion Oily of	Town, State
Itin		4 □ Donation 5 ☒ Other (Specify)  21. Signature of Funeral Service Licens	88-		22. Name and Addre	ass of Facility			
B Per Per Per Per Per Per Per Per Per Per		Anthony	Pleasant	. <del>t</del>		ess of Facility atomy Board a. MD 2120		Baltimore	Street
		23a. Part 1. Enter the disease, or compl	ications that caused	the death. Do not	Baltimore enter the mode of dyn			st,	Approximate
Physician		shock, or heart failure. List only of Immediate Cause (Final disease or condition							Interval Between Onset and Death
/Medical		resulting in death)		ne Intoxi a consequence of):	cation				
Examiner		Sequentially list conditions,	o						
De is	iner	dary leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consagnence of):					
60, be executed icien and burial-transit	Examin	that initiated events resulting in death) Last	Due to /or as	a consequence of):					
760, te be ex ysicien a	aE		Due 10 (01 as	a consequence or,					
687 tificate bg phys	dic		J						
vision of Vital Records, P.O. Box 687 Attending Physician: The law requires that the death certificate r death. sctor: Attent this certificate has been signed by the attending phys the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome					23d. Date of del	verv
death death death death	cla	in the past 12 months?	4☐Pregnant at		3 □Ectopic pregnanc 5 □ Other (specify) _	у		Month	Day Year
P.O. hat the dend by the a setached is	hys	9 Unknown	9□ Unknown						
S, P res that igned to be det	by P	Part II. Other significant conditions con	ntributing to death b	ut not resulting in the	underlying cause giv	ven in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Cord							1 ☐ Yes	2 □ No 3 □ Pr	obably 4 Unknown
Division of Vital Records, i or Attending Physician: The law requires to after death.  Director: Attenthis certificate has been signed in by the funeral director, page 2 should be a	Completed						24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
al Rec	Con						performe Yes 2	ed? death?	
Vital F sicien: Th certificate irector, pag	Be	25. Was case referred to medical examiner?				26. Place of Death	Check only one		
Of \Physical Ithis call dire	မ	X_ 165 2 NO		nt 2 ☐ ER/Outpat		ner: 4 Nursing Hom		ce 6 XOther (Spec	
On oding Fall	in o	27. Manner of Death 1 □ Natural 5 □ Pending	Found Pay	Y Year) 28b. Time (Year) Injur	of unk 28c. Injui	y at 2 rk?	8d. Describe how	injury occurred	unk
isio	cat	2 Accident investigation 3 Suicide 6 Could not be	9-26-05		M 1 =	Yes 2X No	196 Leasting (Ctra	-1	
Div after Dire	Certification:	4 Homicide determined	building, etc	n vacant		1	City or Town,	et and Number or Ru State) 1617 W.	Baltimore S
Hospitai Hospitai 14 hours 8 Funerat I		29a. Certifier 1 Certifying Physics	sician: To the best	of my knowledge, de	ath occurred at the tu	me date and place a	nd due to the cau	se(s) and manner as	atalad
the Ho hin 24 I the Fu mpletely	Medical	(Check only 2 Medical Exami	ner: On the basis of and manner sta	examination and/or	investigation, in my o	ppinion, death occurre	d at the time, date	e and place, and due	to the cause(s)
Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Σ	29b. Signature and title of certifier	1 //	- (	29c. Licens		29d	I. Date signed (Monti	n. Day, Year)
		1 M	1. 14	- for		OCME	SF	EPTEMBER 2	7,2005
		30. Name and address of person who co J. Laron Locke, M		eath (Item 23a) (Typ		Street I			
Sta Registr		31. Date filed (Month, Day, Year)	32 Registra	ar's Signature	noute				
14 31 1 10 3131		NOV 0 1 200	A STORESTONE	at Sal Sal					

CHRISTOPHER DUNCAN STEWART Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-7281

			1 - For State Registrar	State of Maryla	nd / Depa <i>Cei</i>	artment of rtificate o	Health ar f Death	nd Mental Hy	/gier <b>2</b> () () 5 Reg. No.	35238
**	Physici /Medic		1. Decedent's Name <i>(First, Middle, Last,</i> Christopher Dun					2. Date of De Month OCTOBE	Day Yea	11 /(12 D M
	Examir Funeral Director		4a. Facility Name (If not institution, give BRIGHTVIEW ROAD & 5. Social Security Number 6. Sec. 212-23-9545	97 SOUTHBOUN	D s. last birthday) Yrs.			Death	4c. County of D	
	ס	_	Usual Residence of Decedent  10a. State 10b. County		ity, Town or Lo	cation		April 2	22, 19/8	10d. Inside City Limits
	sa or 28a-f	I Director	Maryland Harford  10e. Street and Number  418 Trimblefield	-	gewood	10f. Zip Code 2104(			10g. Citizen of What	,
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any follury or other traumatic svent. The Medical Eventing must be notified at once.	by Funeral	11. Marital Status  1 Narital Status  1 Narital Status  2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in t Armed Forces? 1  Yes 2 No If Yes, Give		Was Decedent of Yes, specify Cu	ıban, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)	Black, W	merican Indian, hite, etc. White
21215-0036	d within 72 ho giene. or then "natur the Medical.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	ilre. L	lent's Usual Occ kind of work dor DO NOT use reti Bondsma	rea)	f working	16b. Kind of Busine	ss/industry
Maryland	should be file and Mental Hy marked othe matic svent.	To Be C	17. Father's Name (First, Middle, Last)  Kenneth J. Stewa  19a. Informant's Name/Relationship (Ty		19h Mailin	an Address /Stm	Bren	Name (First, Middle	,	75-0-41
	1 and 2 s Health an sm 27 is ther trau		Kenneth J. Stewart	, Sr. / Fathe	er 418	Trimble			ewood, MD	21040
Baltimore,	mit. Pages bartment of loortant: If Its finjury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature 1 Funeral Service License	emoval from State	cemetery, crem	natory or other p SS Cemet . Name and Add	ery 20	ov. 2,	20c. Location - City	
m m	e de la company		23a. Part1. Enter the disease, or complete	7.					ome P.A. Burnie, MD	21061 Approximate
8760,	Physician and //Medical by bysician and state of the private transit is the purial-transit.	edicai Examiner	shock, or heart failure. List only/or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):	ucies				Interval Batween Onset and Death
O. Box 6	ath certi	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet: 4 □ Pregnant at time of 6 9 □ Unknown	al death 3 🗌	Ectopic pregnan Other (specify)	су		23d. Date of o	lelivery Day Year
rds, P.	w requires that the de been signed by the a should be detached t	þ	Part II. Other significant conditions con	tributing to death but not re	sulting in the un	derlying cause g	iven in Part I.	23e. Did to	2	to the cause of death?  Probably 4 □Unknown
tai Reco		Be Completed	25. Was case referred to medical				00 80	1 Yes	prior to death  2 No 1 Y	
<u> </u>	Physicia this cer al direct	2	examiner? 1X Yes 2 □ No		ER/Outpatient	JU DON	ther: 4 🗌 Nursir	Death Check only o	dence $6$ $\overline{X}$ Other ( $S_{I}$	Decify) SCENE
Division of Vital Records,	ttending I death. tor: After the funer	Certification:	27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year)  10 - 38 - 55  28e. Place of Injury - At h building, etc. (Speci	28b. Time of Injury  17.00  nome, farm, strefy)	et, lactory, office	]Yes 2. Sooko	operato unich 5 281. Location (S Bright	Street and Number or	ed object
	To the Hospital or A within 24 hours after to the Funeral Directompletely filled in by	edical	29a. Certifier (Crisck only one)	ician: To the best of my known; On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the estigation, in my	time, date and p opinion, death o	lace, and due to the	cause(s) and manner	as stated. ue to the cause(s)
}	1	W	29b. Signature and title of certifier	nia-Poll	el sy	00	ME			9, 2005
	<i>-</i>		30. Name and address of person who co.  31. Date filed (Month, Day, Year)	mpleted cause seath (Iter	KMS	rint) III P	eilli Str	eet Daltl	more, mary	vland 21201
	Sta Registra		NOV 0 1 200	M.	H An	all b				

UNK 05-07304 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. RKD SANJAY S SHETTY State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death OCTOBER 29, 2005 **Physician** Simon Sanjay Peter Shetty 6:06P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAI HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 1 ☑ M 2 ☐ F 8. Date of Birth (Month, Day, Year) Oct 27, 1967 Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Yrs. 219-90-7021 38 Director England Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits r than "natural", or iteme 23a or 28a-f show the Madical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo MD Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Stoney Meadow Court 21093 Great Britain death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify. 3 Widowed 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Disabled N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Yeshvant Shetty Patricia Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Shetty 2 Stoney Meadow Court: Lutherville, MD 21093 mother 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Dulaney Valley Mem Gardens 11/04/05 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD 21. Signature of Funeral Salvage Lipersee 22. Name and Address of Facility 1050 York Road Uly Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complice shock, or heart failure. List only one ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, Dualto (or as a consequanda of) Examiner tary leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy 2 Fetal death in the past 12 months? ö Month Day 4☐Pregnant at time of death Year 5 Other (specify) P.O. 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 0No 3 Probably 4 ☐Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 prior to co death? 1 Yes 2 No 2 No Yes 25. Was case referred to medical 26. Place of Death | Check only one examiner

Division of Vital Hospital or Attending Physician: 10 this Certification: s effer dea.

Hospital: 1 Inpatient 2 KER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 □ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending 10-29-01 1 ☐ Yes 2 ☐ No 2 Accident investigation 16:03 6 Could not be determined 3 Suicide

PEDESTRIAN STRUCK BY A YAN

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) BOSIETANEZ YORKID TUWSON

(Cr sck unity one) 29b. Signafure and title of certifier

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

111 PENN STREET BALTIMORE MARYLAND 21201

Ynell

me Myrae

O.C.M.E.

OCTOBER 30,2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARCHANTA 31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 1/2001

e Funeral Di letely filled in

within 24 ho

To the Function

completely f

Medical

State Registrar

			1 - For State Registrar	State of Maryland	Cei	rtificate of L	Death		2005	35240
			1. Decedent's Name (First, Middle, La	st)				2. Date of Death	1	3. Time of Death
	Physici /Medio		Anthony Henry St	ıpi				Month 10-29	Day Year	12:50A <sup>M</sup>
	Examir		4a. Fecility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	
			210 6th Ave NE			Glen Burn			Anne A	rundel
	Funeral		5. Social Security Number 6. S	DIN OFF	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	rear) C	thplace (State or Foreign ountry)
l.	Director		208-10-2355 Usual Residence of Decedent	88	113.			1-18-1	917 MD	
	/land		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Man L-f eh	to	MD Anne An	rundel G16	en Bur	nie				1 ☐ Yes 24⊒XNo
	r 28s	Director	10e. Street and Number	01.	J. 1. D. 1.	10f. Zip Code		10	g. Citizen of What C	ountry?
	th wit	al D	210 6th Ave NE			21060			U.S.A.	
	eep ee	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	. 13. \	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No-	14. Race - Am	
36	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heath and Mental Pygiene. Important: If item 27 is marked other then "naturel", or items 23a or 28a-f show eny Injury or other traumatic event, the Madical Examiner must be notified at once.	y Fu	1 Never Married 2 Married	1 ⊠ Yes 2 □ No If Yes, Give	•	ires, specify cubar I□Yes 2⊠ No	Specify:	nican, etc.)	Specify: Wh	
Ö	hours ture l'	Completed by	3 ☑ Widowed 4 □ Divorced	Year or Dates:		16				
햣	n 72	jete	15. Decedent's En (Specify only highest gra	ade completed)	(Give	lent's Usual Occupa kind of work done di DO NOT use retired)	tion uring most of work	ing 1	6b. Kind of Business	/Industry
72	with iene.	mo	Elementary/Secondary (0·12)	College (1-4or 5+)		Cutter			Corkran H:	ill & Co
D	Hyg other	Be C	17. Father's Name (First, Middle, Last,				18. Mother's Name			iii a co.
Baltimore, Maryland 21215-0036	uld be Aenta rked tic ev	To B	Joseph Stupi				Veronic	a Valler		
an	sho and h		19a. Informant's Name/Relationship (	• • • • • • • • • • • • • • • • • • • •			nd Number or Rura	al Route Number,	City or Town, State,	Zip Code)
Σ.	end 2 ealth n 27		Veronica Blake /			th Ave NE		urnie, M	D 21060	
ore	Jes 1 of H		20a. Method of Disposition 1 ☑ Burial 2 ☑ Oremation 3 ☐	Removal from State 20b. Pla	ce of Dispos netery, crem	sition (Name of natory or other place	,)	Date 2	Oc. Location - City or	Town, State
<u>=</u>	Pa tmen tant:		4 ☐ Bonation (5 ☐ Other (Specific	(d) (len		Memorial			Glen Burni	Le, MD
ga Ba	permit Deper Impor eny In		21. Signatur of Funer L Service Liger	M/121.1	22	. Name and Address	s of Facility Sin	gleton F	uneral Hom	ne PA
	TO E O G		1 marco	- 11101369					ie, MD 210	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.	Do not ente	er the mode of dying	, such as cardiac o	or respiratory arres	st,	Approximate Interval Between Onset and Death
Jane Jane Jane Jane Jane Jane Jane Jane	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Atherosc	lerot	ic Card	iavascu	lar Dis	eera	y ears
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		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseque	nce of):	s Dis	ease	<del></del>		years
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							,
ó	exec en an rial-tr	Exa	resulting in death) Last	Due to (or as a conseque	nce of):					
68760	ficate be executed g physicien and as the burial-transit	edicai	(	d						
_		Med	IF FEMALE:							
Box	eath certifi attending I for use as	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d	eath 3 🗌	Ectopic pregnancy			23d. Date of de	
	The law requires thet the death cert le has been signed by tha attending lage 2 should be deteched for use a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of dea 9□ Unknown	th 5□	Other (specify)			Month	Day Year
0.	thet ti		Part II. Other significant conditions c	ontributing to death but not resulti	en in the un	derlying cause giver	n in Part I	23e Did toba	cco use contribute to	the cause of doub?
(E	uires thei signed t Id be det	d by		•		acting seeds given	THE COLUMN			obably 4 Unknown
ő	w require been si should b	ete						24a. Was an		
cords	2 2	9		· · · · · · · · · · · · · · · · · · ·				autopsy performe	prior to	topsy findings available completion of cause of
Records	e age	5							RNo 1 □ Vec	
tal Records	00 LL	e Completed	25. Was case referred to medical				26 Place of Death	1 □ Yes 2)		2□ No
r Vital Records,	00 LL	Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ EF	NOutpatient	O45	26. Place of Death	1 □ Yes 2) (Check only one)		
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sion of Vital Records	hysician: this certifica al director. p	To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)		3□ DOA Other 28c. Injury a Work?	4 ☐ Nursing Hor	1 □ Yes 2 (Check only one) me 5 PResiden	ce 6 ⊡Other (Spe	
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State of Maryland / Department of Health and Mental Hygiene 0 5 35241 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October <sup>Day</sup> 26, **Physician** 2005 Elizabeth Marie Sappington 9:36A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County 1113 Plover Drive Halethorpe 8. Date of Birth (Month, Day, Year) Oct. 30,1 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1□ M 🛠 🖼 F Months Days Hours Min 220-20-3678 Director Maryland Usuel Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar mat be notified at 10d. Inside City Limits tX∏XYes 2 ☐ No Funeral Director N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4435 Clydesdale Avenue 21211 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2√ MNo If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: 2 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, It a Market. Elementary/Secondary (0-12) College (1-4or 5+) Meat Cutter ACME Markets 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Michael Fahey Mary Cragnali 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry Sappington Husband 4435 Clydesdale Ave. Baltimore, MD 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State Dulaney Valley 10/28/05 Timonium, Marylan Memorial Gardens

22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc
3631 Falls Road Baltimore, MD 21211 10/28/05 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licentee 21. Signature 23a. Pert1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 4 4/5 Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) ac Jery Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit inding physician and use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 4☐ Pregnant at time of death 5 Other (specify) the detached ģ been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 2 No 1 Tyes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 1 ☐ Yes 2 ☑ No 4 Nursing Home 5 Residence 6 Other (Specify) day 2 2 FR/Outpatient 3□ DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: home 1 Matural 5 Pending М 1 TYes 2 TNo 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4  $\square$  Homicide within 24 hours a To the Funeral C 29a. Certifier 1 🖰 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2001 30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print) esche 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 30, Michael Sorkopud 2005 12:45A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery 8. Date of Birth (Month, Day, Year)
July 12, 1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral**  Birthplace (State or Foreign Country) Months 1**X** M 2□ F Director 261-68-6484 93 1912 Canada Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location wode 10d. Inside City Limits 17 Is marked other then "naturel" or Items 23s or 28s-f ehos traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 🗓 No Directo Montgomery Maryland | Potomac 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 10501 Unity Lane 20854 by Funerai United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify 3X Widowed 4 □ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 Carpenter Carpentry 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Menta! 8 and Mental ၉ Pages 1 and 2 should nent of Health and Mer Not Available Not Available 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
importent: If item 27 Is
eny injury or other trau Patricia Figliozzi/Step-Daughter 10501 Unity Lane, Potomac, Maryland 20b. Place of Disposition (Name of cometery, crematory or other place)
Parklawn Memorial
Park 20a. Method of Disposition 20c. Location - City or Town, State November 1, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2005 Rockville, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signatur of Funeral Service Lice M00803 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Adult Failure to Thrive /Medical Due to (or as a consequence of): Examiner Advanced Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). The law requires that the death certificate be executed ed by the attending physicien end detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death Day Year P.O. | 5 Other (specify) 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Congestive Heart Failure 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 1 Yes 2 X No 1 ☐ Yes 2 ☐ No the Hospitel or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other:  $_{4} \square$  Nursing Home  $_{5} \square$  Residence  $_{6} \boxtimes$ Other (Specify)  $_{1} \square$  Hospice Hospital: ဥ 1 ☐ Yes 2 🕅 No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Injury 1 X Natural 5 Pending investigation death. Director: / 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a To the Funerel I 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and little of certifie 29c. License number 29d. Date signed (Month, Day, Year) 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Harrison, M.D. 6001 Muncaster Mill Road, Rockville, Maryland 31. Date filed (Month, Day, Year) 32. Figistrar's Signature State Registrar NOV 0 2005

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	34,5		Riverview Car 5. Social Security Number	e Cer	nter	7. Age (In yrs.	(a et hirthday)	Essex If Under 1		If Under 2	24 Hrs	8. Date of E		Baltim		In a Chata as Foreign
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State of Maryland / Department of Health and Mental Hygiepe 05 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** DOROTHY TRESHMAN MARIE OCTOBER 27, 2005 8:41 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN WOODS CENTER ROSEDALE BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year, 7/25/1923 Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 212 F Yrs Director 212-20-3359 MARYLAND 82 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location Show 10d. Inside City Limits other treumstic event, the Macked Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD BALTIMORE PARKVILLE 28a-1 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a 3414 UPTON ROAD Funeral 21234 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 2 Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: ģ 3 Widowed 4 Divorced WHITE natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry If Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 12TH GRADE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be rtment of Health and Mental stant: If item 27 is marked o njury or other treumatic eve 2 should be GEORGE LEONARD SIPES OLGA AMANDA BEILMANN 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, MD DONALD J. TRESHMAN, SR./HUSBAND 21234 3414 UPTON ROAD Baltimore. 20b. Place of Disposition (Name of cometery, crematory or other place)
DULANEY XALLEY MEM.
GARDENS 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 Daurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 10/31/2005 COCKEYSVILLE, MD permit. 21. Sign, ture of Funeral Service Licens 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. Depart mpor any in The 8521 LOCH RAVEN BLVD. TOWSON. MD 23a/Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Priysician Syndrome 5 days /Medical Examiner failure exactibation neart uncestive Sequentially list conditions, if any, leading to inflied acuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to fur. is a consequence of) certificate be executed burial-tran and Due to (or as a consequence of) Box 68760 Physician/Medical the as IF FEMALE for use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 | Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4☐ Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records. 2 D No 3 Probably 4 Unknown renul en NR 1 TYes Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2.0 No of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 Tyes 1 Inpatient 2 ER/Outpatient 3∏ DOA Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred After Division 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide or To the Hospital of within 24 hours at To the Funerel D to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 100 wa 30 Name and address of person who completed cause of death (Item 23a) Pype, Print) W rence a 31. Date filed (Month, Day, Year, 32. Registrar's Signature State NOV 0 1 2005 Registrar

		For State	State of Maryland / [	Department of Health and	Mental Hygie	2005	35245
No.		Registrar  1. Decedent's Name (First, Middle, Last)		Certificate of Death	2. Date of Death	. No.	3. Time of Death
Physicia /Medic		Diane Kn	4 Thay		Month	Day Year 29 2005	1:45 p <sup>M</sup>
Examine		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Dea		4c. County of Deat	
	*	GREATER BALTIMORI		TOWSON		BALTIMORE	
Funeral Director		5. Social Security Number 6. Sex 218-46-09-37 Usual Residence of Decedent	11 2 ME	thday) If Under 1 Year If Under 24 Hr Yrs. Months Days Hours Mir		0 00	hplace (State or Foreign untry) TMORL, MO
n the Maryland	tor	10a. State 10b. County	10c. City, Tow	mor Location Marude			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
L A NET Section with the Maryland with 72 hours after death with the Maryland one. Then "natural, or Items 23e or 28e-f ehow he Marified Exercitive tribus De recilied at	Funeral Director	10e. Street and Number 489 Haltowr	Rd	10f. Zip Code 21649	10g	. Citizen of What Co	untry?
r deat	iner		Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (. If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Amer Black, White	
Nours afte	d by FL	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 12 No Specify:	10 110211, 510.)	Specify: W	rite
115-	lete	15. Decedent's Educ (Specify only highest grade	completed)	Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	orking 16	b. Kind of Business/l	ndustry
1 N 7 5	Completed by	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Iministrative Of	fice M.	D Environ	mental Service
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and and		Informant's Name/Relationship (Typ		. Mailing Address (Street and Number or R	lural Route Number, C	ity or Town, State, Z	ip Code)
PC, Mostry of Health item 27 other tr.	1	20a. Method of Disposition	20b. Place of	Disposition (Name of y, crematory or other place)	Date 200	c. Location - City or 1	Town, State
H Limor limor Pages ment of lant; if it luy or o		1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	MINORAL HOLLI STATE 1	Hills Mem. rack 11/	1/05 1	over 1	E
Baltimor permit. Pages Depertment of Important: If it eny injury or e		21. Signature of Funeral Service License	Zentetta	22. Name and Address of Facility	ALTIMORE	MD 212	234
3.5 3.36		23a. Part1. Enter the disease, or complice shock or heart failure. List and on	ations that clused the death. Do r	not enter the mode of dying, such as cardia	oe . Oou Hi	410-0KD 10	Approximate
Physician		Immediate Cause (Final disease or condition	Staphy	lococcus sep			Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequence of	of):			
7 ≃ g	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury	Due to (or as a consequence of				
xecute and Il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	n().			
876( cate be chysicia the bur	dical E	<b>L</b> d.					
9 🚆 5 8		IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregnancy			23d. Date of deliv	
Division of Vital Records, P.O. Box 6 or or attending Physician: The law requires that the death certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as	Completed by Physician/Me	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Month	Day Year
P.C that the detach detach	Phy	9 ☐ Unknown  Part II. Other significant conditions confi		the underlying cause given in Part I	23a Did tohan	co use contribute to	the serves of death?
rds, F quires tha in signed uid be del	g pá	Renal 8	ailure	The didenying cause given in Part I.	1 ☐ Yes		bably 4 Unknown
Recording the law required by the second of	plet	Enceph	alopathy		24a. Was an	24b. Were aut	opsy findings available
al R			/		autopsy performed	l? death? No 1 ☐ Yes	ompletion of cause of
Vital F sician: Th contilicate	D Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 ⊈Inpatient 2 ☐ ER/Out	Other	ath Check only one		
ng Physter this	<u>~</u>	27. Manner of Death	28a. Date of Injury 28b. T	Patient SEI DON 4 I Nuising P	dome 5 Residence		fy)
Sior tendin leath. for: Af	catio	1 ÆNatural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		M 1 Yes 2 No			
Division of Vital Remains Physician: The Within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification; 10	4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)		28f. Location (Street City or Town, S.	tate)	
Div To the Hospital or within 24 hours after To the Funeral Dir completely filled in I	Medical	29a. Certifier 1 Certifying Physic (Check only one) 1 Medicel Exemin	cien: To the best of my knowledge, er: On the basis of examination and and manner stated.	death occurred at the time, date and place for investigation, in my opinion, death occu	e, and due to the cause arred at the time, date	e(s) and manner as s and place, and due t	stated. to the cause(s)
To II withi To III comp	Σ	29b. Signature and title of certifier		29c. License number		Date signed (Month,	
	-	30. Name and address of person who con	U account (Item 23a) (	D0051347		10/31/0	
-1-01		Cynthia Soria	10 MD 6701 N	Type, Print) J. Charles St. Ba	Himore	MD 2121	34
State Registra		31. Date filed (Month, Day, Year)  NOV 0 1 201	32. Registrar's Signature				
DHMH 17 Rev 1/200		NOV 0 1 201	15 Stephen St.	specto.			
			OR	*GINAL			

State of Maryland / Department of Health and Mental Hygiene, 35246 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 31 2005 ALEESE WILSON 4:15 a<sup>M</sup> /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 3433 Elmora Avenue Baltimore N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | SEP 194 5. Social Security Number 6 Say 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 ☐ M 2 1 F 219-20-9271 91 Director NC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits ed other than "naturel", or items 23s or 28s-f ehovevent, the Modical Expedient must be notified at MD N/A Director Baltimore 1 No Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 3433 Elmora Avenue 21213 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Mamed 2 ☐ Marned Maryland 21215-0036 1 ☐ Yes 2 No Specify: black 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Kelly Lewis Martha Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is nany injury or othar traum Ann Blair - daughter 3433 Elmora Avenue, Baltimore, MD Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Inc | 11/1/2005 Beltsville. MD CAFA, Stephen D. Lohrmann, 8717 Green Pastures Drive, 21. Signature of Funeral Service Licenses PA Towson, M01443 21286 23a. Pert Nenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.

Immediate Cause (Final Approximate Interval Between Onset and Death **Physician** neumonia disease or condition resulting in death) /Medical or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Sississ Prijury) that initiated events resulting in death) Last Examiner burial-transit death certificate be execut and Due to (or as a consequence of): 68760, the attending physician Physiclan/Medical as the Box ( IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, pe 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 1 clescy Division of Vital 1 ☐ Yes 2 ☐ No 1 Yes 2 ₩0 To the Hospital or Attending Physicien: 25. Was case referred to medical examiner?

1 \( \sum \text{Yes} \) 2 \( \sum \text{No} \) Be 26. Place of Dea (Check only one) Other: 4 Nursing Home Hospital: ၉ 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 5 Lesidence 6 □Other (Specify) this 27. Mann Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 Pending investigation within 24 hours after use.....
To the Funeral Director: After 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of 29d. Date sigged (Month, Day, Year) 10/31/05 land cause of daith (flem 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2005 G

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-	Funeral Director		5. Social Security Number 070-18-8617	6. Sex 1 <b>⊠</b> M 2□F	7. Age (In yrs. 8 1		If Under 1 Year Months Days	If Under 24 Hi Hours Mi		<sup>Year)</sup> 1924 9. Bi	nthplace (State or Foreign Sountry) New York
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	a-f sh	ctor	Md. Baltin	nore		Dundal	.k				1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number				10f. Zip Code		10	0g. Citizen of What C	Country?
	s 23a	rai	8152 Midhaven 1				21222			USA	
39	be filed within 72 hours after death with the Maryland Ital Hyglene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examinar matter positied at	by Funerai	11. Marital Status  1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	ried Armed Fo	2 □ No		Was Decedent of Hi f Yes, specify Cuba 1 □ Yes 2∏ No	spanic Origin? ( n, Mexican, Pue Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh Specify: Wh	ite, etc.
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lary	ges 1 and 2 should it of Health and Men if item 27 is marke or other traumatic.		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	g Address (Street a	and Number or F	Rural Route Number,	City or Town, State,	Zip Code)
e o`	lealth m 27 her tr		Marion Wexler	Wi	.fe				Dundalk,MD	21222	
Baltimore, Maryland 21215-0036	Pa men ant:	100	20a. Method of Disposition  1    Burial 2 □ Cremation  4 □ Donation 5 □ Other (Si		State C	emetery, crem .ly Hil	sition (Name of natory or other place .1 Memoria	al 3,	2005 M	20c. Location - City or Iiddle Rive	er, MD
Bal	permit. Departr Importa any inji		21. Signature of Funeral Service	· Con	nelly	/ Cc	Name and Address nnelly Fu 10 Soller	s of Facility Ineral H Is Point	Iome Of Du Road, Du	ndalk,P.A ndalk,MD.	21222
	Pnysician /Medical Examiner	ner	23a. Part 1. Enter the disease or shock, or heart failure. this Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a Due to (c		CATO uence of):				uetastatic	Approximate Interval Between Onset and Death
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.O. Box	that the death certificated by the attending produced for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		rth 2 ☐ Fetal ant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
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Vital	icien: Th certificate rector, pag	a	25. Was case referred to medical					Of Blace of De		No 1 □ Yes	2 No
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/	To with	2	29b. Signature and title of certifier	Ufar	har		29c. License	832	6	d. Date signed (Monti	1/2005
4			30. Name and address of person v	SHAR MI				CENTE	R, BA	LTIMORE,	MD.2(22/
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Registrar

OCTOBER

MARYLAND WHALEN

2005

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	Physic			trell	Will							2. Date of D Month	Da		'ear	3. Time of Death
	/Med Exami		4a. Facility Name (I				>	4b. City, T	own, or	Location of		Octobe		. County of		11:10 P <sup>N</sup>
,			Good Sam	itan Hosp	ital			Bali						N	A	
	Funeral		5. Social Security N	umber 6. S		Age (In yrs. )		If Under 1		If Under	Min.	8. Date of Bi (Month, D	av. Year.	9	). Birthp	place (State or Foreign htry)
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	ryland how		10a. State	10b. County		10c. City	, Town or Lo	ocation							1	0d. Inside City Limits
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9	be filed within 72 hours after death with the Maryland ntal Hygiene.  ad other than "natural", or items 23a or 28a-f show event, it a Modical Examinar must be notified at	臣		ed 2 Married	Armed Force	ss?			-	n, Mexican	gm / (Spe i, Puerto F	cify Yes or No Rican, etc.)	0-	14. Race - Black,		
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3altimore,	permit. Pag Department Important: I any injury o		4 ☐ Donation  21. Signature of Fuj	5 Other (Specify		MH	· Carr	ne/Ce	met	erey No	ovembe	,5,2005	Ba	Himo	ne	MD 4. 206-5105
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	Physician		Immediate Cause (I	t failure. List only		73 / 4A	1,00	ud.	10	an	na i	2001	20	A		Interval Between Onset and Death
	/Medical		resulting in death)		a. Due to (or	a a consequ	ence of):	0-07	10	WY.	// (	w W (	·wu		+	
	Examiner	L	Sequentially flat our	ditions,	b	Marian Company										
	nsit	Examine	if any, leading to impose. Enter Under Cause (Disease or in	mediate lying njury	Due to (or	as a consequ	ence of):								F	
7	execunand nand	Exar	that initiated events resulting in death) L		c Due to (or	as a consequ	ence of):								-	
8760,	the death certificate be executed y the attending physicien and sched for use as the burial-transit	dicai			d.											
9	ntifica ng ph a as th	Med	IF FEMALE:						_							
Вох	eath certific attending p	Physician/Me	23b. Was decedent in the past 12 r	program		2 Fetal	death 3	Ectopic preg	nancy				1	23d. Date of		•
o.	he de	ysic	1 ☐ Yes 2 ☐ 9 ☐ Unknown		4□Pregnant 9□Unknowr	at time of dea	ath 5⊡	Other (spec	(ty)					Month	ı	Day Year
<u>α</u>	res that the digned by the be detached		Part II. Other signific	cant conditions co	entributing to death	but not resui	ting in the ur	iderlying caus	se given	in Part I.		23e. Did to	obacco u	se contribut	te to the	cause of death?
Vital Records,	requires that een signed b rould be deta	leted by						_	ŭ				res 2			bly 4 Dunknown
900	law requii as been s 2 should	plete										24a. Was	an	24b. Were	e auton	sy findings available
ĕ	The ate has page	Compl										autop perfo	rmed?	prior	to com	pletion of cause of
/ita	Physician: The this certificate h ral director, page	Be	25. Was case referre	ed to medical			allwi		2	26. Place o	of Death (	Check only o	-		Yes 2	P.□ No
	를 다 글	5	Y☐ Yes 2☐ N 27. Manner of Death	lo	Hospital: 1 ☐ Inpa	. 4	R/Outpatient		Other:	4 🗀 Nurs	sing Home	5 ☐ Resid	dence 6	☐Other (S	Specify)	
	ding After fune	Certification:	1 Natural	5 Pending	200 27 27	Day Year)	28b. Time of Injury	28c.	Work?			d. Describe t	now injury	occurred	j .	4
/isi	Attending r death.	fica	2 Accident 3 Suicide	6 Could not be determined	28e. Place of I	niury - At hon	ZZ:40		1 ☐ Ye	s 2 2 2 N		t Location (9	CCAL	Number	> KL	Pouts Number (
á	s afte	Cert	Homicide	determined	building,	etc. (Specify)	3400	F			72				2017	Route Nymber. C
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier (Check only	Certifying Phy	sician: To the be	st of my know	edge, death	occurred at t	he time,	date and	place, an	d due to the		and manner	r as sta	434 ted.
	the H hin 24 the F hplete	Medical	one)		and manner	Or examination	on and/or inv	estigation, in	my opir	ion, death	occurred	at the time, o	date and	place, and	due to t	he cause(s)
	To To	2	29b. Signature and ti	tle greetifier	100	$\Lambda\Lambda$			OCMI				29d. Date	signed (M	onth, D	ay, Year)
1				VVV	rv	V (								oer 27		
	7		30. Name and addres	ss of person who c	ompleted dayse of	death (Item 2	23a) (Type, F	Print) 111	Per	ın Sti	reet	Balt	imore	e, Mar	yla	nd 21201
4 0	Sta	te	31. Date filed (Month	Day, Year)	32. Regis	trar's Signatu	re									
	Registr	ar	NC	V 0 1 20	15		, 1	M -								
DHM	/H 17 Rev 1/20	01	,116	V 1 40		100	1	N/W					-			
							ORIGIN	AL								

State of Maryland / Department of Health and Mental Hygiene Reg. NG 005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death WETZEL Year **Physician** BLAR OCTOBER 28 2005 01:10 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TONSON BARMOR center CHECTNUT GREEN nealta 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 29, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
2. FERN. Funeral 1⊠M 2□ F Months Days Hours Min. 1922 405-36-1498 83 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other then "natural", or items 23a or 28e-f show traumatic event, the Medical Examinar must be notified at MD Baltimore Towson 1 ☐ Yes 2 1 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1055 W. Joppa Road 21204 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health end Mental Hygiene. Important: If Item 27 is marked other then "natural", or item eny Injury or other traumatic event, the Medical Examination. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: White þ 3 M Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Logistics Engineer Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Beulah Harter Wetzel Harry ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Wetzel/daughter 726 Holliday Lane, Westminster, Maryland 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Hilltop Svc. Corp. 10/31/2005 Towson, MD. 4 ☐ Dopation 5 ☐ Other (Specify) 21. Sign fre of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Stephen Coster 1050 York Road, Towson, Maryland 21204 Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Ceribrusaserua ditente jews Examiner Due to (or as a consequence of) Examiner physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) esn is certificate has been signed by the a director, page 2 should be detached Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☑ Unknown concer þ Be Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Denventa completion of cause of death? 1 ☐ Yes 2) No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No Certification: To To the Hospital or Attending Physi within 24 hours efter death.

To the Funeral Director: After this completely filled in by the funeral dir Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Rem 23a) (Type, Print)

AND LOS MY (GO) V. Character St. Powsov, NO 2(LOY) D58303 OCTOSE 28 2005 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Server & Specie Registrar

**DHMH 16 Rev 6/95** 

DHMH 17 Rev 1/2001

State Registrar ITEDORE MIKELLE

2005

31. Date filed (Month, Day, Year)

32. Registrar's Signature

			1 - For State of N	Maryland / Depa	artment of H			giene 00	5 35252
	Physici		Decedent's Name (First, Middle, Last)     Andrew	Young	1		2. Date of De. Month Octobe	Day \	3. Time of Death 11:45 A M
	/Medio Examir		4a. Facility Name (If not institution, give street and number		4b. City, Town, o	r Location of Death	OCLOBE	4c. County of	Death
	<b>.</b>		1814 Marshall Road  5. Social Security Number 6. Sex 7. A	Age (In yrs. last birthday)	Dunda If Under 1 Year	lk If Under 24 Hrs.	8 Date of Birt	Baltir	
ŀ	Funeral Director		212-16-8957	83 Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da November	11,1921	Birthplace (State or Foreign Country)     MD.
	aryland show	7	10a. State 10b. County  MD Baltimore	10c. City, Town or Lo					10d. Inside City Limits
	the M	Director	10e. Street and Number	Duridati	10f. Zip Code			10g. Citizen of Wh	1 Yes 2 Mo
	23a or	al Di	1814 Marshall Road		21222	!		USA	u. 554,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any rightry or other treumatic event. If a Marylaid Exartina must be neithed at once.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Deceder Amed Force: 1 NYSes 2 If Yes, Give Year or Dates	s? ]No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. White
5-0	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	eation during most of work d)	ing	16b. Kind of Busi	ness/Industry
Maryland 21215-0036	t within jiene. r than	Completed	Elementary/Secondary (0-12) College (1-40 10 years	(5+)	DO NOT use retired llwright	d) -		Bethlehe	m Steel
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ryla	d Ment d Ment markec natic e	은	Henry James Young  19a. Informant's Name/Relationship (Type, Print)	405 14-17		Kunigund			
	nd 2 sl alth an 27 Is r ir treur		Mary C. Young wife			and Number or Rur . Road, Di			ate, Zip Code)
Baltimore,	Pages 1 a nent of Hez int: If itam iry or otha		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal from Stat  4 □ Donation 5 □ Other (Specify)	20b. Place of Dispo cemetery, crer Sacred Hear	natory`or other plac		ember 2005	20c. Location - Ci	-
Balti	permit. Departr Imports any injit		21. Signature of Funeral Service Licensee	ary	7110 Soll		Road,	Dundalk,	P.A. MD. 21222
l.			23a. Part T. Enter the disease or complications that caus shock, or heart failure. Light only one cause on each	ed the death. Do not ent line.	er the mode of dyin	ig, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
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8760,	death certificate be executed as a strengting physician and dor use as the burial-transit and	ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	s a consequence of):					
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<u>α</u>	The law requires that the tee has been signed by th bage 2 should be detache	þ	Part II. Other significant conditions contributing to death	but not resulting in the ur	nderlying cause give	en in Part I.	23e. Did to		ute to the cause of death?  Probably 4 □Unknown
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Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:		Oth	26. Place of Deatl			
of	g Physier this teral di	n: To	27. Manner of Death 28a. Date of In	ient 2 ER/Outpatien	t 3∐ DOA 28c. Injun Worl	4   Nursing Ho		ence 6 Other owninjury occurred	(Specify)
sior	lending I eath. cor: After the funer	catio	2 Accident investigation		M 1 🗆	Yes 2 No			
DΪΧΪ	tal or Attenders after death al Diractor:	Certification:	determined 286. Place of II	njury - At home, farm, stro etc. <i>(Specify)</i>	eet, factory, office		28f. Location (Si City or Town		or Rural Route Number,
	To tha Hospital or Attending Ph within 24 hours after death. To tha Funeral Diractor: After th completely filled in by the funeral	edical	29a. Certifier (Check only one)  Certifying Physicien: To the besis and manner s	of examination and/or inv	occurred at the tin restigation, in my op	ne, date and place, pinion, death occurr	and due to the c ed at the time, d	ause(s) and manne ate and place, and	er as stated. due to the cause(s)
	To tha within 2 To tha complet	Σ	29b. Signature and title of certifier		29c. License		2	9d. Date signed (A	Month, Day, Year)
0		-	30. Name and address of person who completed cause of	death (Item 23a) (Type		5254		10/31/6	25
C'			Carole Miller MD	9005 Ca	ton a.	re BALT	om,	3175	9
	Sta Registr	_	31. Date filed (Month, Day, Year) 32. Reg	rar's Signature	Soules				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 5 per fh 9850 12-8-05 vt. State of Maryland Department of Health and Mental Hygierie 0 5 35253 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 29, Francis Ziomek Oct. 2005 10:15a<sup>™</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Catherine Nursing Home Emmitsburg Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security N3664 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 7 / 25 / 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1**X**M 2□ F Months Hours 219-07-<del>1922</del> 83 Yrs. Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. shirt If item 27 is marked other than "neturel", or Items 23s or 28e-1 show 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "neturel", or Items 23s or 28e-f show treumetic event, the Medical Examinat manual be modified at 1 Yes 2 □No Director Baltimore Md n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 USA 2441 Fleet Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 1942-45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Laborer General motors 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lawrence Ziomek Josephine Knasiak 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sr. Joan Drega, D.C. 333 S. Seton Ave. Emmitsburg, Md. 21727 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of IImportent: If ite
eny injury or ot
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Stanislaus \* 4 ☐ Donation 5 ☐ Other (Specify) 11/2/05 Baltimore, Md. 21. Signature of Funeral Service Lich Raczorowski Funeral Home P.A. 1201 Dundalk Ave. Baltimore, Md. 21222 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Days Pneumonia /Medical Due to (or as a consequence of) Examiner Days Debility Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Endstage Metastatic Prostate Cancer 6 Years resulting in death) Last Due to (or as a consequence of) Box 68760. physician Be Completed by Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown à signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Dementia page 2 s autopsy performed? 1 ☐ Yes 2 No 1 Yes 2.2 No director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) Certification: To 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending after death. 2 Accident investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide filled in 24 hours a Lectifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) Bonuta H0044037 October 29, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bonita J. Krempel-Portierdo 52 Water St. Thurmont, Md. 21727 Joanse 32. Registrar's Signature

DHMH 17 Rev 1/200

State

Registrar

31. Date filed (Month, Day, Year)

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		-	For State of Ma	ryland / Depa	artment of F		lental Hygie	711115	35254
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	/Medic		la. Fecility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death		4c. County of Deat	
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	DU A	1	Usual Residence of Decedent  10a. Slate 10b. County	10c. City, Town or Le	ocation				10d. Inside City Limits
	lanyii	5	MD N/A	RΔI .	TIMORE				1 ☐ Yes 2 ☐ No
	28a-	Directo	10e. Street and Number	DAL	10f. Zip Code	<u> </u>	10g.	Citizen of Whal Co	untry?
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Σ.	1 end 3 Health em 27 sther tr		RAZANA DRAGUN / DAUGHTER					BALITMUKE c. Location - City or	, MD 21215
altimore,	00		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State		matory or other pla	ce)			
Ē	tment tant:		4 ☐ Donation 5 ☐ Other (Specify)			CEM 10/30		EISTERSTO	
Ba	permit. Pages Department of Important: If i any injury or on		21. Signature of Funeral Service Ligensee		22. Name and Addre			N & BROS. KESVILLE,	, INC. MD 21208
	-		23a. Part . Inter the disease, or ample the sthat caused should or heart failure. List only one cause on each lin						Approximate Interval Between
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ā	iclan: Th certificete rector, pag		25. Was case referred to medical	60X		26 Place of Deat	1  Yes 2 h Check only one	TNo T Yes	2 No
₹	Physician: r this certifice ral director, p	To Be	examiner?  1 Yes 2 No Hospital: 1 Impatie.	nt 2□ ER/Outpatie	ent 3 DOA Ott	nar.		e 6 Other (Spe	cify)
ō	g Phys er this ieral dii		27. Manner of Death 28a. Date of Injur	y 28b. Time			28d. Describe how	injury occurred	
0	Attending I ir deeth. ector: After by the funer	atio	2 Accident investigation	,,		Yes 2□No			
Division of Vital Records,	or Attendater deet Director:	Certification;	3 Suicide 6 Could not be determined 28e. Place of Inju	ury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ural Route Number,
	To the Hospital or Attending Physician: The within 24 hours after deeth.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page		393 Conflict  (Check only  2 Medical Examiner: On the basis of	of my knowledge, det	oth occurred at the ti	me, date and stace.	and due to the caus	se(s) and manner as	stated.
	the Hin 24 the Fu	Medicai	one) and manner sta						
	To To t	Σ	29b. Signature and title of certifier	- MD	29c. Licen:	se number 54352		Date signed (Mont	7. Day, Year) 29 2005
•	~							-(0,500	3 2003
	3		30. Name and address of person who completed cause of de NOTTHWEST HOSPITAL		-D COURT	ROAD TO	RANDALL	stown	MD 21133
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registra NOV 0 1 2005	ar's Signature	Cartes				

1. Decoderifs Name (First, Middle, Last)   1. Decoderifs Name (First, Middle, Missin Surane)   1. Decoderifs Name (First, Middle, Missin Su			For State	State	of Marylan	d / Depa	artment <i>tificate</i>	of H	ealth a	and Mo	ental Hy	giene ()	05	35255
Mary Bilen Atkinson  Stringhord  31254 Chesterville Bridge Road  Millington  Stringhord  1206-120-8269				Last)								eath		3. Time of Death
4. Tooling Name (if for a relation) price was an anament of the case of the ca			Mary Ellen	Atkinso	าท									2:40a <sup>M</sup>
31254 Chesterville Bridge Road  Willington  220-52-8269							4b. City, T	own, or	Location of	of Death	000.			
Special Security Number 2   5 - 5 xx   2 xx   5 xx   2 xx   5 xx   2 xx   5 xx   2 xx   5 xx   2 xx   5 xx   2 xx   5 xx   2 xx   5 xx   2 xx   5 xx   2 xx   5 xx   2 xx   5 xx   2 xx   5 xx   2 xx   5 xx   2 xx   5 xx	Examin	e.		-		Road	Mi	114	nata	on		K	ent	
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Top. State   Min			220-52-8269	1 □ M 2/Δ F	90	Yrs.	Months	Days	Hours	MIII.	12/19	71914		MD
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15. Mother's Name (First, Middle, Makisan Sumane)   16. Mother's Name (First, Middle, Makisan Sumane)   17. Father's Name (First, Middle, Makisan Sumane)   18. Mother's Nam	nat	ete	15. Decedent's (Specify only highest	s Education grade completed	)	(Give	kind of work	done d	u <i>ring</i> mos	t of workin	g	16b. Kind of	Susiness/	industry
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William C. Brown    Table   March   Ma	lygie ther t			asti		1101								curring
19a. Informant's Nama/Pelationship (Type, Prott)   19b. Mailing Address (Sireet and Number or Rual Route Number, City or Town, State, Zip Code)   21   220   230	d la g	<b>6</b>								_		_		
Paige Morton/Daughter 31250 Chesterville Bridge RD Millington,  20a. Maynod cipsposition   Date   Da	J Mer nark	은	10a Informatio Name/Relationsh	in (Tune Print)		10h Mailie	a Addross /	(Stroot a	nd Numbe	ar or Rumi	Route Numi	ner City or Town	n State	Zin Code)
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23a   Pifft   Erier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate cause limiting in death)   Security   Secu	2 = 2		1 Burial 2 Cremation		State	emetery, cren	natory or oth	ner place					•	
23a   Pifft   Erier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate cause limiting in death)   Security   Secu	tant:				₩e	-		- House and the same of the sa			22/05	Rock	Hal	.1, MD
Pysician Medical Xaminer  Table 10	Depar Impor any In		21. Signature of Funeral Service L	icensee		22 I	Name and Fello	WS	s of Facilit Hel	fenk	ein a	& Newn	am F	uneral H
Interesting in dealth of automatical standing and the self-independent of the			23a. Part1. Enter the disease, or o	complications that	caused the death	n. Do not ent	er the mode	of dying	y pre	cardiac or	respiratory a	arrest,	עויי	Approximate
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Sequentially list conditions   fary, leading to immediate cause. Enter Underlying that initiated events			disease or condition				Cava	י לרסו	Hoce	ear;	115ec	206		syears
Due to (or as a consequence of):    Due to (or as a consequence of):	xaminer		_	Due to	(or as a consequ	uence or):								
Due to (or as a consequence of):    Due to (or as a consequence of):	0.00	-	Sequentially list conditions,	b. Due to	(or as a consequ	uence of):								
Due to (or as a consequence of):    Due to (or as a consequence of):	nsit	- L	cause. Enter Undertying Cause (Disease or injury											
IF FEMALE:   23b. Was decedent pregnant in the past 12 pronths?   1   Ves   2   No.   9   Unknown   24a. Was an untopsy performed of cause of death?   1   Yes 2   No 3   Probably 4   Unknown   9	al-tra	xai	that initiated events	c	(or as a consequ	uence of):								
IFFEMALE: 23b Was decedent pregnant in the past 12 gronths?   1	Siciar			L										
239. Was observed the pregnant at time of death   2   Fetal death   3   Cctopic pregnancy   Month   Day   Year	phy:													
1   Yes 2   No 3   Probably 4   Unknow	nding sea	ZM										23d. D	ate of de	ivery
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autopsy performed? 1   Yes 2   No    25. Was case referred to medical examiner?   26. Place of Death (Check only one)  27. Marner of Death   1   Notatural   28a. Date of Injury   28b. Time of Injury	deta		Part II. Other significant condition	s contributing to	death but not resu	ulting in the ur	nderlying ca	use give	n in Part I		23e. Did	tobacco use co	ntribute to	the cause of death?
autopsy performed? 1   Yes 2   No    25. Was case referred to medical examiner? 1   Yes 2   No    25. Was case referred to medical examiner? 1   Yes 2   No    26. Place of Death (Check only one)  27. Marner of Death 1   Inpatient 2   ER/Outpatient 3   DOA    28. Date of Injury   28b. Time of Injury   28b. T	sigr Id be		Hy vertensi	n							10	Yes 2 No	3 ☐ Pr	obably 4 Unknow
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25. Was case referred to medical examiner?    1	has 9e 2	du									auto	psy	prior to	completion of cause of
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27. Manner of Death 1 Chaldrain 2 Security 27. Manner of Death 1 Chaldrain 2 Security 27. Manner of Death 1 Chaldrain 2 Security 27. Manner of Death 1 Chaldrain 2 Security 27. Manner of Death 2 Security 3 Suicide 4 Homicide 28a. Date of Injury 4 Security 3 Suicide 4 Homicide 28b. Time of Injury 4 Security 3 Security 4 Security 3 Security 4 Security 5 Security 6 Security 7 Security 8 Security 8 Security 8 Security 8 Security 8 Security 9	sertifi ector	8	examiner? _ /	Hospital:				Othe	÷		10	_		
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  20a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	this aldir	$\vdash$		1				1	4 🗀 140					cify)
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filed (Month, Day, Year)  32. Registar's Signature	urs a	O								, No				
and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  548 or 1 Poss in D. 516 Weshington And Classes that All 20  State  31. Date filed (Month, Day, Year)  32. Register's Signature	Fund Fund (ely fi	lica	(Check only 2 Medical E	xeminer: On the	pasis of examinat									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Susan L. Ross in D. 510 Woshington And. Claster time Md. 21620  State  31. Date filed (Month, Day, Year)  32. Registar's Signature	the hin 2 the mplet	Med					290	License	number			29d. Date sign	ed (Mont	h. Dav. Year)
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State 31. Date filed (Month, Day, Year) 32. Registar's Signature  OCT 2. 1 2005	~		30. Name and address of person w	no completed cau	se of death (Item	23a) (Type,	Print)	N.	01	,	, .	1.1 7.1		
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	111		Jusan K. Ku	iss in I	5/6	Washi	regton/	1.4.	Cl	wootes	tome /	1K 216	20	
		_	31. Date filed (Month, Day, Year)	1 2005	Hegitar's Signal	ture 🌽	1000	20						

State of Maryland / Department of Health and Mental Hygiene 0 0 5 35256 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** HOLGER CHRISTIAN ANDERSEN OCTOBER 12, 2005 15:27 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHESTER RIVER HOSPITAL CENTER CHESTERTOWN KENT | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. (Month, Day, Year) | MARCH 7, 1918 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ₹M 2 □ F 87 359-05-3455 Director ILUsual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show MD Director 1X Yes 2 □ No KENT CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 238 437 HERON POINT 21620 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? \*natural', or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 Yes 2 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien. Important: If item 27 is marked other that any injury or other traumatic event, their page. CHEMIST PRECIOUS METALS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, AXEL B. ANDERSEN OLGA A. EASTERHOPE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANCES B. ANDERSEN/WIFE 437 HERON POINT, CHESTERTOWN, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State CHESAPEAKE CREMATION OCT. 13, 2005 STEVENSVILLE, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
130 SPEER ROAD, CHESTERTOWN, MD 21620 21. Signature of Funeral Service Licenses bun tella ant1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ATHEMSCLEROTIC Pnysician HEARLY DISGASE 1 hour /Medical **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner transit The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician a for use as the burial-P.O. Box 68760 Physiclan/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ DIABETES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed ATRIAL FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performe certificate DEMENTIA Division of Vital 1 Yes 2 S No the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Unpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of After t Certification: 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending s after dec. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2005 D0041587 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 122 SPEER RD CHESTERTOWN, MD 21620 NOBLE MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

		For State Registrar	State of N	Maryland / Dep <i>Ce</i>	artment of H		d Mental Hy	giene Reg. No. 0	15 35257
Physic		1. Decedent's Name (First, Middle	,				2. Date of Do Month	Day r 04, 20	3. Time of Death 9:24 p <sup>M</sup>
/Medi Exami		MARIA OFELIA A 4a. Facility Name (If not institution		ar)	4b. City, Town, or	Location of D		4c. County	
		PRINCE GEORGE'	S HOSPITAL		CHEVERLY			PRINCE	E GEORGES
Funeral Director		5. Social Security Number	6. Sex 7 1 ☐ M 2 ☐ X	Age (In yrs. last birthday 76 Yrs.	If Under 1 Year   Months   Days		lin. (Month, D	rth ay, Year) 12,1929	9. Birthplace (State or Foreign Country)  GUATEMALA
the Maryland 28a-f show	ector	Usual Residence of Decedent  10a. State 10b. County  MARYLAND PRINCI  10e. Street and Number		10c. City, Town or L				10g. Citizen of V	10d. Inside City Limits 1 (▼Yes 2 □ No
with la or 3	ij		Ctmoot		20737			GUATEM	-
IDIC, INICITYICILIC ZIZID-UDDO  ges 1 and 2 should be filed within 72 hours after death with the Maryland  t) of Health and Mental Hygiene.  If item 27 is marked other than "natural", or Items 23a or 28a-f show  or other traumatic event, the Modical Examinar must be notified at	ed by Funeral Director	11. Marital Status 1 Never Married 2 Marria 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Yes 2	s? <b>X</b> No s:	Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 No	n, Mexican, Pi Specify:	(Specify Yes or N Lerto Rican, etc.) UATEMALA	o- 14. Rac Blac Specify	ee - American Indian, ck, White, etc. HTSPANIC
ithin 72 an 'nat	Completed		st grade completed)  College (1-4c	or 5+) (Give	edent's Usual Occupa e kind of work done of DO NOT use retired	during most of )	working		•
d Z I Z I		9th 17. Father's Name (First, Middle,	I act)		OMEMAKER	18 Mother's I	Name (First, Middle	DOMEST	
aryiding should be fi nd Mental F marked of umatic ever	To Be	UNKNOWN	Lasty			UNKNO	OWN		
INGI nd 2 sho alth and 27 is m		19a. Informant's Name/Relations WALTER E. ANDRA	_		ing Address (Street a				
of Hez		20a. Method of Disposition  1   Burial 2 □ Cremation	2 DRomoval from Sta	20b. Place of Disp	osition (Name of matory or other place	e)	Date	20c. Location -	City or Town, State
Page Thent ant: If		'4 □Donation 5 □ Other (S	pecify)	Cementeri	o Jotabaj		/12/05		Guatemala
Dallillore, IVI permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		21 Signature of Funeral Service	Licensee A	/	2. Name and Addres  O Kennedy				ios Funeral. INC C. 20011
Physician (and physician and physician and physician and the purial-transit the purial-transit the purial purial purial physician and the purial purial purial physician and physician and purial purial purial purial physician and purial purial physician and purial physician and purial physician and purial physician and purial physician and purial physician and purial physician and purial physician and purial physician and purial physician and phys	dicai Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Ather Due to (or a	osclerotic as a consequence of): as a consequence of): as a consequence of):	Cardiovas	cular B	leart Dis	ease	Inferval Batween Onset and Death
The law requires that the death certific. The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		2 Fetal death 31 at time of death 5	Ectopic pregnancy Other (specify)				te of delivery nth Day Year
w requires that been signed b	by	Part II. Other significant condition	ons contributing to death	n but not resulting in the t	underlying cause give	en in Part I.			ribute to the cause of death?  3 Probably 4 MUnknown
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vician: Th	Be (	25. Was case referred to medical examiner?			0.1		Death (Check only		
Attending Physic relation After this coetor: After this coetor: After this coetor the funeral dire	ion; To	1 X Yes 2 No  27. Manner of Death 1 X Natural 5 Pendin			of 28c. Injury Work	at	g Home 5 Res 28d. Describe	idence 6 Other	
in the state	Certification:	2 Accident investigned Accident Suicide 6 Could determined	not be 28e, Place of	Injury - At home, farm, st etc. <i>(Specify)</i>		103 20,10		(Street and Numb wn, State)	er or Rural Route Number,
To the Hospital within 24 hours a To the Funeral I completely filled	edical C			st of my knowledge, dea of examination and/or in stated.					
To the vithin 2 To the comple	Med	29b. Signature and title of certifie		3 12 -	29c. License		G27		d (Month, Day, Year)
(2)		30. Name and address of person	who completed cause o	f death (Item 23a) (Type	/ 4 !	7053	171	OCLODE	r /8 , 2005
		Salvador Sylve 31. Date filed (Month, Day, Year)	ester, M.D.	; 3001 Hosp	ital Driv	e; Chev	erly, Man	ryland :	20785
St: Regist	ate rar	OCT 1 8 2	005	strar's Signature	de				

State of Maryland / Department of Health and Mental Hygiene 0 0 5 crn Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 12, 2005 10:52 P <sup>M</sup> AVENT October 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6960 Hawthorne Street Landover Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1XM 2□ F Months Days Hours Yrs Director 213-86-5787 JULY 15, 1974 MARYLAND Usual Residence of Decedent with the Maryland ahow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahor Tre Medical Examiner roust be notified at MD PRINCE GEORGE LANDOVER 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2337 VERMONT AVE U.S.A. 20784 death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iter any injury or other traumatic avant, the Medical Examinat Black, White, etc. 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK ð 3 Widowed 4 Divorced leted 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11th CONSTRUCTION PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) LARRY ROBINSON BELINDA LEWIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BELINDA AVENT/MOTHER 2337 VERMONT AVE LANDOVER, MD 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10-20-2005 RIVERDALE CREMATORY RIVERDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 7474 LANDOVER RD LANDOVER, MD 20785 1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MULTIPLE EUNSHOT /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the deeth certificate be executed as the buriat-transit Due to (or as a consequence of) Records, P.O. Box 68760 the ettending physicien Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐ Pregnant at time of death 5 Other (specify) detached 9☐ Unknown 9 Unknown been signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1. Yes 2 \( \) No 24a. Was an autopsy performed? Division of Vital 12 Yes 2 🗆 No in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other:  $_{4\,\square\,\text{Nursing Home}}$  5  $_{\Box}$  Residence 6  $_{\Box}$ Other (Specify) at scene ၉ 1X Yes 2 □ No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: al or Attending F after death. After 5 Pending 1 Naturai Injury 10:05PM 1 Yes 2 No SUBTED WAS 2 Accident investigation SHOT 10/12/05 Diractor: 6 Could not be determined 3 🔲 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 6960 HAWTHORNE To the Hospital within 24 hours a To the Funeral C pelli STREET BAUTITORE, MI) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME October 13, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 ANA RUB10, 31. Date filed (Month, Day, Year) 2. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

1 8 2005

Please	Type or	Print in	Black Indelibi	le ink.	Ensure	All Copies	Are Legible.

			1- For State of Maryland / Department of Certificate of	Health and N Death	∕lental Hygi Re	ene 200	)5 (	35259
	Physici		1. Decedent's Name (First, Middle, Last)  Bertha Elizabeth Austin		2. Date of Death Month	Day	Year 2005	3. Time of Death
)	/Medio Examir		4a. Facility Name (If not institution, give street and number), PININSUIN SEQUENCE MEDICAL CLASSE 4b. City, Town,	or Location of Death	_	4c. Count	y of Death	•
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 263-82-9417 101 Yrs. Months Days		8. Date of Birth	904	9. Birthpl	ace (State or Foreign
	<u>. ≃</u> ⊽		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10	Od. Inside City Limits
	Ba-1 eh	Director	Maryland Wicomico Salisbury					1 ☐ Yes <b>2√</b> ☐ No
	th with t	ai Dir	10e. Street and Number 1514 Riverside Drive 10f. Zip Code 218		10	g. Citizen of US <i>I</i>	What Count	try?
336	urs after dee al', or Itema	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Amed Forces?  1 Never Married 2 Married  1 Yes 2 No If Yes, Give 1 Yes or Dates:		pecify Yes or No- Rican, etc.)	Bla	ce - America ack, White, e fy: whi	etc.
21215-0036	be filed within 72 hours after deeth with the Maryland Hylgiene. Hylgiene Hylgiene dother then "natural", or tema 23e or 28e-f ehow event, the Modical Exeminer must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  12  16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retin	e during most of work ed)	cing		Business/Ind	·
덛	m ~ 0 5	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, M.	aiden Suma	me)	
Maryland	2 should be and Mental Is marked of raumatic eve	J.	Roy Burnett Smith  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Stree		eth Sophi			Code)
e, X	1 and 2 Health a bm 27 Is		Janice A. Cook/daughter 806 Camden 20a. Method of Disposition (Name of					Chil
Baltimore,	Pages nent of I ant: if It		20a. Method of Disposition  1  Burial 2 XCremation 3 Removal from State  4 Donation 5 Other (Specify)  Salisbury Cremator	)			- City or To	
Balt	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic evonce.		21 Segmature of Europea Service Ligenses 22, Name and Addr HOLIOWAY	ess of Facility Funeral	Home Prof	essio	nal As	ssociation
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Physician /Medical Examiner		2 a. Part . Efter the disease, or complications that caused the leath. Do not enter the mode of dy shock or heart failure. List only one cause in each line.  Imme ate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	v Hill Rd.			D ZIO	Approximate Interval Between Onset and Death
68760,	g physicien and as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):					
.O. Box	ine law requires thei the death centil ste has been signed by the ettending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	э <b>у</b>			ate of deliver	ry Day Year
cords, r	en signed to	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause go	ven in Part I.	23e. Did toba		3 ☐ Proba	e cause of death? ably 4 Unknown
VIIIai neco	oing Prysician; The law re The Affer this certificete has be funeral director, page 2 shr	Be Completed	ACUTE PENAL FAILURE  25. Was case referred to medical examiner?	26. Place of Deat	24a. Was an autopsy performs 1 Yes 2)		prior to com death?	osy findings available npletion of cause of 2 X No
> . 5 i	r this ce	٥	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA		ome 5 Residen			)
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.i		edical Ce	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the to the basis of examination and/or investigation, in my and manner stated.	opinion, death occur	red at the time, dat	e and place,	and due to	the cause(s)
,	Toth	ž	29b. Signature and title of certifier 29c. Licen	se number	290	d. Date signe	ed (Month, E	)ay, Year)
Ł	Ind 1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	-006031-	>	10/1	8/03	> .
	Stat Registra		29b. Signature and title of certifier  29c. Licen  29c	1011 St.	Salisi	bury	MD	21801

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Amend

State of Maryland / Department of Health and Mental Hygiege

			1 - For State Registrar		n 24a per	verh	o.,G851,	Media 6	Healtr	n and r th	Mental Hy	glene Reg. No	11115	352	260
	Physici	an	Decedent's Name (First,     A / - A			Ď.					2. Date of De Month	ath Day	y Ye	ar	e of Death
	/Media	cal		unci			ner				10	19	20	05 18	05 M
	Examir	ier	4a. Facility Name (If not ins	titution, giv	re street and numbe	7)		4b. City, Town,			1		County of E		
			5. Social Security Number	6.9	Sex 7. A	ne (In vrs	. last birthday)	Oct Ucin		ler 24 Hrs.	8. Date of Bir		Sarr		
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	yland Now		10a. State 10b. C			10c. C	ity, Town or Lo	cation						10d. Insid	e City Limits
	Mar-	ţċ	MD Ga:	rrett		Fri	endsvi	lle						10	Yes 2 <b>∑</b> No
	th the	Director	10e. Street and Number					10f. Zip Code				10g. Cit	zen of Wha	t Country?	
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စ္	72 hours after death with the Maryland natural', or Items 23a or 28a-f show disal Examiliat rusil be multified at	Funeral	11. Marital Status  1 Never Married 2	] Married	12. Was Deceden Armed Forces 1 ☐ Yes 2 ☐ ff Yes, Give	?	1				pecify Yes or No Rican, etc.)	)-	Black, V	American India: Vhite, etc.	٦,
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Maryland	should be nd Mental marked o	To Be	Lester Thomas	S							rtha Tho		Surrame		
ary	s 1 and 2 should f Health and Men item 27 is marke other traumatic	-	19a. Informant's Name/Rel	ationship (	Type, Print)		19b. Mailin	g Address (Stree	et and Num	nber or Ru	al Route Numb	ər, City o	r Town, Stat	e, Zip Code)	
	1 and 2 Health Iem 27 i		Awilda D. Fi	ke/Da	ughter			-		Rd.,	Friends	vill	e, MD	21531	
Baltimore,			20a. Method of Disposition 1   Burial 2 □ Crema	ation 3 [	Removal from State	20b.	Place of Dispos cemetery, crem	sition (Name of atory or other pi	ace)		Date	20c. Lc	cation - City	or Town, State	Э
Ë	Pa Interpretation		'4 □Donation 5 □ Ot	ner (Specia	5)		er Glad	de Cemet	ery (	oct.	23,2005	Frie	endsvi	lle, M	D
3ai	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Se	ervice Lice	10	)		Name and Add			ewman Fi				Α.
	40240		220 Part Fator to disco		ferma						tsville		ryland		
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	/Medical Examiner		rosalling in dozin)	- (	Due to (or a	s a conse	uence of):	1 Sel	100					1/	
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oʻ	rificate be executed og physician and as the burial-transit	Еха	resulting in death) Last	- 1	C. Due to (or a	s a consec	quence of):								
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0.		Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pregnant a 9□Unknown	at time of o	death 5	Other (specify)					Month	Day	Year
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Record	aw request speen	Completed									24a. Was	an	24b. Were	autopsy findin	gs available
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Viita	sician: The certificate irector, pag	Be C	25. Was case referred to m	edical					26. Pla	ce of Deat	1 ☐ Yes h (Check only o				
<u></u>	Physic this ce	2	examiner?		Hospital: Inpat		ER/Outpatient	3□ DOA O	4		ome 5 🗋 Resid		Other (S	pecify)	
20	ng Pl		27. Marrier of Death	ending	28a. Date of Inj (Month, D	ury ay Year)	28b. Time of Injury	28c. Inju			28d. Describe h				
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•	1 = 1		30: Name and address of pe	on who	completed cause of	death (Iter	n 23a) (Tyne F	Print)	391	19		10	(U,S		
	4		Robort L	5 6	12/100c	i. M	7 31	IN. C	DUIN	46 K	st., Oa	111	and	MD.	21550
	Sta		31. Date filed (Month, Day,		32. degist	rar's Signa	ature		المالياا		· J. VI	110	×119(,		- 1900

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Amend item#21, perFH, 6849, 11-1-05, TT
State of Maryland Department of Health and Mental Hygiene OF 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** PM 9:00 10 George Ronald Bailey 16 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Wicomico Wicomico 34208 West St. Pittsville If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Months Hours 1 ★M 2 F 9/29/1937 Director 220-32-7933 68 MD Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show traumatic event, the Madical Examiner must be notified ut MD 1 ☐ Yes 2x No Completed by Funeral Director Wicomico Pittsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 34208 West St. 21850 Items 23a Wicomico filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Myes 2 No If Yes, Give Year or Dates: 1956-58 1 ☐ Never Married 2 ☑ Married ö Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Sawmill 9 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 12 should ba fill and Mental H Be Ellen Collins George Bailey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 sment of Health an ant: If item 27 Is ury or other trau Nancy Bailey Pittsville, MD 21850 34208 West St. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 10/20/2005 Pittsville, MD Parker Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 W. Kirk Burbage (per DVR) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ¿ brain mets KIUIT. /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transit that the death certificate be executed Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by HIM 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 22 No Division of Vital To the Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 2 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ☐ Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours a To the Funerel L Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier HOO61327 mare 10119105 Name and address of person who completed cause of death (Item 23a) (Type, Print) C.H. 4+1 Salisbury MD Your 31. Date filed (Mon egistrar's Signature 1 9 2005 State Registrar

		1	For State Registrar	State of Maryla		partment of H <i>ertificate of I</i>		ntal Hygie		35262
	Physicia		Decedent's Name (First, Middle, Last		1.	L	2	. Date of Death Month	Day Year	3. Time of Death
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	F		Chester Kive 5. Social Security Number 6. Se	x Hospital	. last birthda	ay) If Under 1 Year	If Under 24 Hrs. 8	Date of Birth	Sen 9. Bin	hplace (State or Foreign
	Funeral Director		218–16–6926	□M 2ŽIF 8		Months Days	Hours Min. A	Date of Birth (Month, Day, Ye UG. 29, 19	324	MD MD
	nyland how		Usual Residence of Decedent  10a. State  10b. County	1	ity, Town or					10d. Inside City Limits
	the Ma 28a-f s	recto	MD KENT  10e. Street and Number		ROCK	10f. Zip Code		10g	Citizen of What Co	1 X Yes 2 No puntry?
	ath with	Funeral Director	5598 SOUTH MAIN S			216			USA	
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'lanc	ald be fi	To Be	CHARLES B. DAVIS					R. AYRES		
Maryland	nd 2 shoul Ith and Mo 27 Is marl 1 traumati		19a. Informant's Name/Relationship (7) MELISSA L. HILL/G			ailing Address (Street TRELLIS WA				Zip Code)
altimore,	Pages 1 an nent of Heal int: If itam 2 iry or other		20a. Method of Disposition  1   ↑ Burial 2 □ Cremation 3 □  ↑ 4 □ Donation 5 □ Other (Specify	Removal from State	cemetery, o	sposition (Name of crematory or other place CHAPEL CEM		00	c. Location - City or ROCK HAL	
Balti	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licens	lelkenten)		22. Name and Addre FELLOWS, 130 SPEER	ss of Facility HELFENBEIN ROAD, CHE	& NEWNA	M FUNERAL	L HOME, P.A.
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	plications that caused the decone cause on each line.	ath. Do not	enter the mode of dyin	ng, such as cardiac or	respiratory arrest	•	Approximate Interval Between Opset and Death
	Pnysician /Medical	1 9	Immediate Cause (Final disease or condition resulting in death)	a. Delvid Due to (or as a onse	equence of):	<i>y</i>				2 days
	Examiner	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	nguence of):					4 days
	ocuted ind transit	Examln	cause. Enter Underhang Cause (Disease or injury that initiated events resulting in death) Last	c. Paren	17	*				4 Rays
68760,	ate be executed bhysician and the burial-transil	edical Ex	resulting in death, East	Due to (or as a conse	iquence or):					
_	ertificate ding physise as the l	/Medi	IF FEMALE:	23c. If yes, outcome of preg	nancy				23d. Date of de	làvo=:
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death	3 Ectopic pregnancy 5 Other (specify)	/		Month	Day Year
ds, P	ires tha signed I I be det	þ	Part II. Other significant conditions of	ontributing to death but not re			ren in Part I.	23e. Did tobac		the cause of death?
cor	law require as been si 2 should b	Completed	- ich (der 1 - des ob	- 3.000	, ,,,,,	13		24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
of Vital Records,								performe	d? death? No 1 ☐ Yes	
f Vit	S 2	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: Inpatient 2	☐ ER/Outpa	atient 3 DOA	26. Place of Death (		e 6 Other (Spe	ocify)
	ng Pt fter th		27. Manner of Death  T Natural 5 Pending  2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Tim Inju	ry Wor	y at 28 rk? Yes 2 □ No	d. Describe how	injury occurred	
Division	Hospital or/Attending 24 hours after death Funeral Director: After tely filled in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined			, street, factory, office	28	of. Location (Stree City or Town, S	et and Number or R State)	ural Route Number,
	To the Hospital or Attendi within 24 hours after death To tha Funeral Director: A completely filled in by the fa	edical C		ysicien: To the best of my ki niner: On the basis of exami and manner stated.						
)	To th withir To th comp	M	29b. Signature and title of cellifier	)	ND	29c. Licens	51735	29d	Date signed (Moni	th, Day, Year)
(	7)5		30. Name and ad person who	completed cause of death (It	em 23a) (Ty	rpe, Print) CHU2CH	HILLE	DICHE	STERION	21630 MD
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	9.31		ACT 11	2005 Here	A Sto					

			1 - For State Registrar	State of	Marylar	nd / Depa <i>Ce</i>	artmer <i>rtifica</i> i	nt of H te of L	ealth a Death	and M	lental Hy	giene	-	5 (	35263
	Dhusisi		Decedent's Name (First, Middle, I	Last)			~				2. Date of De			Vana	3. Time of Death
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П	Funeral Director		579-44-3209	. Sex 1 □ M 2 □ F /.	Age (in yrs.	. last birthday) Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da	y, Year)		9. Birthp	lace (State or Foreign
			Usual Residence of Decedent								March 1	10,1	919	wasn	ington DC
	s 1 end 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "nature!, or items 23s or 28s-f show other traumatic event, the Madical Exeminal must be notified at	or	10a. State 10b. County MOntgor	nery		ity, Town or Lo								11	0d. Inside City Limits 1 X Yes 2 No
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lar	Aental Aental rked c	To B	James V. Browne	11					Anna	Mon	ie Myer				
Maryland	2 should and Men Is marke aumatic	-	19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street a	nd Numbe	r or Rura	I Route Numb	er, City o	r Town, S	State, Zip	Code)
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Baltimore,	permit. Pages 1 Department of H Important: If Ite any Injury or ot		21. Signature of Funeral Service Lic	ensee		22	Name ar JOS	ad Addres	awle	r's S	Sons,IN	C			
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Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification;	3 Suicide 6 Could not determine		Injury - At he etc. (Specif	ome, farm, stre	eet, factory	, office		2	8f. Location (S City or Tox	Street and vn. State,	d Number	r or Rural	Route Number,
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			Charles Harri				er M	<b>il</b> l H	Rd.,R	ockv:	ille,MD	208	355		
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 35264 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician AUSTIN DENNESEARL BROWN **OCTOBER** 2005 7:20 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GENESIS HEALTH CARE LA PLATA CHARLES If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year, MAY 9, 193 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1₩ 2□F Months Days Hours 1938 WASHINGTON, D.C. Director 215-34-3282 Usual Residence of Decedent with the Maryland 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "neturel", or items 23s or 28e-f show treumatic event, the Medical Examinar treust be indified at 1 Yes 2 No Director MARYLAND CHARLES INDIAN HEAD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5333 SMITH DRIVE 20640 UNITED STATES death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after or and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: Specify: þ 3 X Widowed 4 □ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12TH GRADE College (1-4or 5+) CORRECTIONAL OFFICER COUNTY GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be EUGENE BROWN FRANCES DUDLEY BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 s of Health an DEMETRIUS BROWN / SON 5333 SMITH DRIVE, INDIAN HEAD, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 nent of P ant: If ite 1 Burial 2 Cremation 3 Removal from State ö permit. Page Department of Importent: If any injury of ST. MATTHEWS CHURCH CEMETERY 10/8/2005 NEWTOWN, MARYLAND <sup>1</sup> 4 □ Donation 5 □ Other (Specify) LYDIA C. THORNION JOHNSON MO0583 THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each\_line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 10 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ cate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐ Yes 25 No Division of Vital Physicien: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: P 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Director: After thin by the funeral 27. Magner of Death Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No M 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 - Homicide thin 24 hours aft the Funeral Dimpletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 286. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 13 Alexande 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road, #110 hwerdale H400 Queensbury 31. Date filed (Month, D gistrar's Signature State 8 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Day Month Year Ida L. Biscoe 5:15 PM October 0 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Heritage Harbour Health & Rehab. Ctr Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours 1 ☐ M 2 ☐ XF Yrs. 579-32-9467 Sep. 25, 1918 North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ¥ Yes 2 □ No Maryland | Prince George's Mitchellville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 10204 Greenspire Way 20721 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify 3 TV Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Housewife Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hugh Cullen Vick Katie Dupree 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda B. Robinson/Daughter 10204 Greenspire Way, Mitchellville, MD 20721 20b. Place of Disposition (Name of cemetery, crematory or other place). 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State 4 □ Qonation 5 □ Other (Specify) Maryland National Mem. 10/18/2005 Laurel, MD 21. Signature of Pineral Service Licenses 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C. u.e (Final disease or c. orition resulting in death) Sepsis Due to (or as a consequence of): Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Lung Cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Dehydration 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 XNo Pneumonia 1 ☐ Yes 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo

Physician /Medical Examiner attending physician and for use as the burial-transit

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this funeral

After

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after death

To the Hospital or within 24 hours af To the Funeral D completely filled in

**Physician** 

/Medical

Examiner

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**Funeral** 

Director

item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at

permit. Pages 1 and 2 should be filled within 72 hours atter to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any injury or other traumatic event, the Medical Examinat once.

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records.

or Attending Physician:

death with the Maryland

Examiner Physician/Medical þ Completed Be 2 Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

3 Suicide

29a. Certifier

4 Homicide

25. Was case referred to medical

27. Manner of Death 5 Pending 2 Accident

investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifig

31. Date filed (Month, Day, Year)

and manner stated

29c. License number

29d. Date signed (Month, Day, Year) October 17, 2005

30. Name and address of person who completed cause of death (Item 23a) Type, Print)

Njide Udochi, M.D. 9055 Chevrolet Dr., #100, Ellicott City, MD

State Registrar

OCT 1 9 2005

State of Maryland / Department of Health and Mental Hygiegie 05 35266 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Year 5:40 P M October 11 2005 Matthew Leo Batteau /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's Magnolia Center Lanham If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 DM 2 □ F Yrs Director 95 454-05-9020 June 11, 1910 Texas Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 27 is marked other then "neturel", or items 23a or 28e-f show treumatic event, the Madical Examinar must be restilled at 1 XYes 2 No Prince George's Maryland Ft. Washington Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene, "returel", or Items 23 a may injury or other treumatic event, the Modified Examinations once. 106 Swan Creek Road 20744 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 □XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black ۵ 3 □ Widowed 4 □ Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Tucson Unified School Elementary/Secondary (0-12) College (1-4or 5+) 6+ Educator District 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Armstead Batteau Easter Bryant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Flavia Batteau Walton/Daughter 106 Swan Creek Rd., Ft. Washington, MD 20744 20b. Place of Disposition (Name of Exercise property) Mount Least y 20a Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 10/20/05 onation 5 Other (Specify) Cemetery & Mem. Park Tucson, AZ 21. Signat e of Fur eral Service Licenses 22. Name and Address of Facility Stewart Funeral Home lw 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part1. Ther the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca se (Final disease or condition resulting in Fath) Physician Sepsis Days /Medical Due to (or as a consequence of): Examiner Aspiration Pneumonia Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) anding physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) ed by the attending physician detached for use as the burial P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Tes 2 No 3 Probably 4 Unknown Dementia Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Dysphagia 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2**X** No Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral dir this 27. Mapper of Death 1 Natural 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred After 5 Pending investigation after death.

I Director: Aff 1 ☐ Yes 2 ☐ No 2 🗌 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated within 2 To the 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 29c. License number D01852 October 14, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul A. DeVore, M.D. 4203 Queensbury Rd., Hyattsville, MD 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar OCT 1 9 2005

State of Maryland / Department of Health and Mental Hygiere 055 35267 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Melquiadez Limin Basilio October 15. 2005 1:48 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Doctors Community Hospital Prince George's Lanham If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, April 23, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Min Yrs. 219-19-5911 66 Philippines Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show r than "natural", or items 23e or 28a-f shov The Modical Examinar must be notified at 1 ☐ Yes \$ X No **Funeral Director** Maryland Prince George's Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 400 Aqua Lynn Drive 20744 LISA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene important: If item 27 is marked other than "natural; or item any injury or other traumatic event, the Medical Expense 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 201 No Specify: Filipino Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6th Carpenter Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pedro Basilio Paulina Limin 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Belationship (Type, Print) 400 Aqua Lynn Drive Ledelia C. Basilio / Wife Ft. Washington, Maryland 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 10/22/2005 Cedar Hill Cemetery Suitland, Maryland ` 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signatury Fu of Service Lucinee 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each the. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician CANCER OF RECTUM 3 years /Medical Due to (or as a consequence of) Examiner STENOSIS OF COLOSTOMY year Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consciouence off Examine The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical the use as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown δ Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4XIZUnknown Diabetes Mellitus Type II Completed Asthma 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 25 KNO XXYes 2 No 1 TYAS Division of Vital the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes XX No 1 🔼 Inpatient P 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After XXNatural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No s after death 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 \ Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MDD 19591 October 15, 2005 30. Name and address of person o completed cause of death (Item 23a) (Type, Print) MD Limpuangthip Thong 7721 Belle Point Drive Greenbelt, Maryland 20770 31. Date liled (Month, Day, Year) State 1 9 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** 4, SUSIE BERRY October 0 2005 2:42pm /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Prince Georges TNSURANCE ELDER CARE
5. Social Security Number 6. Sax College Park

10 Onder 24 Pirs.
Hours Min.
Min.
March 14,1906 If Under 1 Year Birthplace (State or Foraign Country) 7. Aga (In yrs. last birthday) Funeral Days 1 ☐ M 2 🖳 F Months Yrs 99 411-36-0504 Tennessee Director Usual Residance of Decedent permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, Stata 1 Yas 2 No Director College Park Md. Prince George's 10g. Citizan of What Country? 10f. Zip Coda 10e. Street and Number Funeral 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) U S A 14. Hace - American Indian, 9115 St. Andrews Place 12. Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Giva Yaar or Datas: Black, White, atc. 1 ☐ Navar Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yas 2 No Specify: **Black** Specify: <u>ک</u> 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 15. Dacedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) Teacher Private 18. Mothar's Name (First, Middla, Maidan Surnama) 17. Father's Name (First, Middla, Last) Be George Evans Mattie Kline 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 20 Mello Road Wellesley. Massachusetts 02482 Richard McGhee/Nephew 20b. Placa of Disposition (Name of cemetary, cramatory or other place) Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition tXXBurial 2 ☐ Cramation 3 ☐ Ramoval from Stata Maryland National Cem 10/12/05

22. Nama and Addrass of Facility

Johnson & Jenkins Inc.

2. 2001 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Frunaral Sarvice License 716 Kennedy St., N.W. Wash. .D.c 20011 23a. Part1. Entar tha diseasa, or comblications that causad the leath. Do not antar tha moda of dying, such as cardiac or respiratory arrast, shock, or haart failure. List only ona cause on aech line. Approximata Interval Batween Onsat and Daath Physician Immediata Cause (Final disaasa or condition rasulting in death) /Medical SENILE DEMENTIA Examiner Due to (or es e consequance of): Physician/Medical Examiner MALNUTRITION igned by the attanding physicien and be detached for use as the burial-transit Sequantially list conditions, if any, laading to immadiate causa. Entar Undarlying Causa (Disease or injury that initiated avants rasulting in daath) Last Dua to (or es a consequance of): Division of Vital Records, P.O. Box 68760, WEIGHT LOSS Dua to (or as a consequanca of): 23b. Did tobacco usa contributa to tha cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown been signed Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1⊡Yes 2⊒No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) assited Other: 4 Nursing Home 5 Rasidence X Other (Specify) 1iving Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 1 ☐ Yes 27 No After this 28a. Data of Injury (Month, Day Yaar) 28b. Tima of 28c 28d. Describe how injury occurred 27. Menner of Death Certification: 1 Natural 2 Accidant 5 | Pending 1 Yas 2 No daath. invastigation i Director: A 6 ☐ Could not be determinad 3 Suicide 28f. Location (Straat and Number or Rural Route Numbar, City or Town, State) Place of Injury - At home, farm, straat, factory, office building, atc. (Spacify) 4 Homicide To the Hospital or A within 24 hours aftar To the Funerel Direct aftar 29a. Certifier **XXCertifying Physician:** To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) and manner as statad Medical 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner steted. (Check only one) 29d. Data signad (Month, Day, Year) 29c. Licansa number 29b. Signatura and titla of certifian D19935 10/17/05 30. Nama and address of person who complated cause of deeth (Item 23a) (Type, Print) Samuel Deshay, M.D. 2025 East West Highway, Silver Spring, Md Registrar's Signatura 31. Dete filed (Month, Day, Year) State OCT 1 9 2005 Registrar

DHMH 16 Rev 6/95

ORIGINAL

Certificate of Death

Approximate Interval Between Onset and Death 041

Year

3. Time of Death

9. Birthplace (State or Foreign

White

10d. Inside City Limits 1 Yes 2 □ No

Maryland

14. Race - American Indian, Bfack, White, etc.

Specify:

6:00 A M

2005

Due to (or as a consequence of)

IF FEMALE:

Physician/Medical

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Completed

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Certification:

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After

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after death.

To the Hospital or Attending Physician:

23b. Was decedent pregnant in the past 12 months? 9 Unknown

resulting in death) Last

23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 2 Fetal death 4 Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

autopsy performed? 1 Yes 2 3100

26. Place of Death | Check only one

24b. Were autopsy findings available prior to completion of cause of death?

25. Was case referred to medical examiner' 1 ☐ Yes 2 1 10 27. Mann eath 1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

Hospital:

1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of

3 DOA 28c. Injury at Work?

Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number D-31912

30. Name and address of person what implet a cause of death (Item 23a) (Type, Print)

MENO(MM nD. JU40 31. Date filed (Month, OCT 1 9 2005 32. R

5 Pending

investigation

6 Could not be determined

1564 DPUSSUMJUUN PINE, MEDERICH MD 21702

State Registrar

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760

ORIGINAL

1 Certifying Physician: To the cost of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examination: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiepe 35270 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** OCTOBER 17 2005 ALBERT BRENNER 5:10PM M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner TALBOT HOSPICE HOUSE EASTON TALBOT If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day, Year) FEB 11 1911 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**▼** M 2□ F Months Days Hours Min NEWYORK 067-14-1540 94 Yrs. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits or 28a-f show item 27 is marked other than "neturel", or items 23a or 28a-f show other treumatic event, it a Medical Exertiner must be retilled at 1 ☐ Yes XX No Director MD TALBOT OXFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26568 E. BONFIELD ROAD 21654 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE If Yes, Give Year or Dates: 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 0 VICE PRESIDENT MANUFACTURING permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent; if item 27 is marked oth any injury or other treumatic event otte. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SAM BRENNER FANNIE HITZIK 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WENDY BISHOP/DAUGHTER 26568 E. BONFIELD ROAD, OXFORD, MD 21654 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State \* 4 □ Donation 5 □ Other (Specify) CHESAPEAKE CREMATION CTR 10/20/2005 STEVENSVILLE, MD 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST EASTON, MD 21601 21. Signature of Funeral Service Licensee Soseph OSTROWILL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** cely disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown signed by the Rant IL Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an has autopsy certificate 1 Yes 2 No Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 2 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 XOther (Specify) HOSPICE this 27. Mainner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After or Attending 1. Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funerel C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 10 23a) (Type, Print) inpleted cause of a and address of person MCNONLAL MD

Registrar DHMH 17 Rev 1/2001

State

Registrar's Signature

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2005

			1 - For State Registrar	State o	of Marylai	nd / Depa <i>Ce</i>	artment of H	lealth a Death	and Me		ieme 0 0	5 35271
	20.0		Decedent's Name (First, Midd	lle, Last)					2	. Date of Deat	h	3. Time of Death
ı	Physici /Medio		Lillian	Leigh	Beauch	amp			10	Ctober	Day	Year /2 45pm
	Examin		4a. Facility Name (If not institution PUNISULA REGI	/ // 44	IMPORT)	renter	4b. City, Town, or	Location of	of Death		4c. County	of Death
	Funeral Director		5. Social Security Number 21.7–10–2355	6. Sex 1 ☐ M 2 H F	7. Age (In yrs 86	. last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours		Date of Birth Month, Day 13/19	l <sup>Ygar)</sup>	9. Birthplace (State or Foreign Country) Virginia
	pu k		Usual Residence of Decedent  10a. State 10b. Count	<i>y</i>	10c C	ity, Town or Lo	ocation					10d. Inside City Limits
	l sho	ö	Maryland Wico		100.0	Salisk						1 ☐ Yes Ž ☐ No
	28a-	Directo	10e. Street and Number	MILLO		Dalisk	10f. Zip Code			10	0g. Citizen of W	/hat Country?
	3a or	0	124 Philli	p Morris I	Drive		218	04			USA	,
	death	nera	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Ori	gin? (Speci	fy Yes or No-		- American Indian,
ဖွ	or its	Ē	1 ☐ Never Married 2 ☐ Ma	rned 1 ☐ Yes	2 🔼 No		irres, specny Cuba 1 □ Yes 2 🏝 No			can, etc.)	Specify:	k, White, etc. White
8	ural',	d b	3 X Widowed 4 □ Divorce	d Year or D	Dates:							
2	within 72 hours after death with the Maryland ene. then "natural", or iteme 23s or 28s-f ehow to Madical Examiner must be notified at	iete	15. Deceder (Specify only higher	nt's Education est grade completed)		16a. Dece	dent's Usual Occup: kind of work done o DO NOT use retired	ation <i>during</i> mosi fi	t of working	. 1	16b. Kind of Bus	siness/Industry
7	withi iene. then	Completed by Funeral	Elementary/Secondary (0-12)	College (	1-4or 5+)		operator	,			Office	Supply
פ	ai Hygie other	BeC	17. Father's Name (First, Middle								Maiden Sumame	e)
ylaı	should be and Mentai smarked o umatic eve	ToE	Kirby Hood No	ttingham,	Sr.			Myr	tle Mu	use		
Mar	d 2 shoth and the and traum		19a. Informant's Name/Relation Terry G. Beau				ng Address <i>(Str</i> eet a				-	
ē	s 1 and f Health item 27 other to		20a. Method of Disposition		20b.	Place of Dispo	sition (Name of		Dat			City or Town, State
Ë	Pages nent of I nnt: If its ury or o		1   Burial 2 □ Cremation  1 □ Donation 5 □ Other (3		State Sp	oringhi Garden	Tatory of other place II Memory	7	10/21	/05	Hebron,	, MD
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentai Hygiene. Important: If item 27 is marked other then "natural", or Iteme 23a or 28a-f show eny injury or other traumatic event, tra Medical Examinat must be notified at one.	<	21. Signature of Funeral Service	Licensee	CFS	SP 22		Funer Hill	al Ho	me Proi	fession	al Association 21804
	7		23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that	caused the dea							Approximate Interval Between
	Physician		Immediate Cause (Final	it only one outself								Onest and Dooth
•			disease of condition		nalina	2110	4	ac	ride	at .		Onset and Death
5,	/Medical		disease or condition resulting in death)	a. Due to	relux (or as a conse	quence of):	rular	ac	cide	nt		Onset and Death
S		1	resulting in death)	a. Due to		quence of):	enlar	me	cide ma	nt		Onset and Death
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State of Maryland / Department of Health and Mental Hygiena 35272 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) October 5,2005 **Physician** Marjorie Vaughan Crawford 3:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11402 Chantilly Lane Upper Marlboro Prince George If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth
(Month, Day, Year)
July 21, 1930 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Malace Tomaca **Funeral** 1 □ м 24€ Г 224-34-6922 75 Lawrenceville Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State 27 is marked other than "naturel", or Itams 23a or 28e-f show treumatic event, the Madical Examiner must be notified at Yes 2 □ No Director Maryland Prince George Mitchelleville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number With W 20721 11402 Chantilly Lane United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian e filed within 72 hours after cal Hygiene.
Other than "naturel", or Itan 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married **Black** 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify ۾ 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry DC Health and Human College (1-4or 5+) Elementary/Secondary (0-12) Twe1ve Six Physical Therapist Services 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be fill and Mental H is marked off Charles R. Vaughan Kate Travis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) is 1 and 2 s of Health an item 27 is 1 Garfield Crawford/Husband 11402 Chantilly Lane, Mitchellville, Maryland 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of He
Importent: If iter
any injury or oth 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial ParkOct 13,2005 Landover, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert G. Mason Funeral Home 21. Signature of Euneral Service Acenses 1661 Good Hope Rd SE, Washington DC 20020 23a. Part f. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alzheimer's Disease **Physician** /Medical Due to (or as a consequence of): Examiner Carcinoid Carcinomatosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ed by the attending physician and detached for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has 1 ☐ Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Locetion (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funerel L 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 14,2005 25434 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Chisholm M.D. FACP 106 Irving Street NW #2000, Washington DC 20010 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar OCT 1 8 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 005 1 - For State Registrar 35273 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 6 Macie Pearl Cummings 1:50 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Goodwill Mennonite Home Garrett Grantsville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth March Day Year March 26,1927 9. Birthplace (State or Foreign Months Days Hours 1 □ M 2 X F 78 Maryland 165-24-4704 Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 ☐ No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2021 Downsville Pike, Apt. 24 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Dorsey Fike Pearl Humberson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Fike/Nephew 3044 Bumble Bee Rd., Accident, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State Cedar Lawn Mem. Park Oct. 27,2005 Hagerstown, MD ^ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. mak 10/23/05 unna P.O. Box 275, Grantsville, MD 21536 23a. Part (En) if the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final aspiration preumonia disease or condition resulting in death) 22 month cerebral Vasaclar accident 22 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury my pertension that initiated events resulting in death) Last intermittent atrial fibrillation IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? severe osteo authoritis 1 Yes 2 0 3 Probably 4 Unknown 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No breast cancer 1 Yes 2 **X**No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death

**Physician** /Medical Examiner been signed by the attending physician and should be detached for use as the best of the second to t Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

Director

Completed by Funeral

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Examiner

Physician/Medical

Completed

Be

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Certification:

Medical

Funeral

Director

77 is marked othar then "neturel", or Items 23a or 28a-f show treumatic event, the Medical Exact or must be notified at

Baltimore, Maryland 21215-0036

ould be filed within Mental Hygiene. al Hygiene.

is marked

permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic events.

23b. Was decedent pregnant

1 Natural 2 Accident

3 Suicide

31. Date filed (A)

4 Homicide

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

5 Pending investigation

28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signature

1 🗌 Yes 2 🗌 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature and title of certifier

6 Could not be determined

gwrett highway

29c. License number

30. Name and address of erson who completed cause of death (Item 23a) (Type, Print)

5e1, ud

State Registrar

filled in by

within 24 hours a

			Please Type or Print in Blace State of Maryland /					•		gible.	35274
		-	1 - For State Registrar	Cert	tificate of	Death		R	eg. No.		00214
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day	Year	3. Time of Death
	Physicia /Medic		LAURA CATHERINE WILLIS COVING	TON				Oct		2005	9:40 PM
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, o				4c. Cou	inty of Death	
			Genesis HealthCare - The Pin			aston				Talb	
	Funeral Director		5. Social Security Number  215-38-1305  Usual Residence of Decedent  6. Sex 1 □ M 2   7. Age (In yrs. last to 101)  101	Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day)	Year) 1904	Co	nplace (State or Foreign untry) YLAND
	d within 72 hours after death with the Maryland giene. Tr then "natural", or Items 23a or 28a-f show the Majical Examinar must be nullited at	٥	10a. State 10b. County 10c. City, To		ation SPRING						10d. Inside City Limits 1 X Yes 2 ☐ No
	the N	Director	10e. Street and Number	, v LIK	10f. Zip Code				Oa Citizen	of What Co	untry?
	with with		1735 OVERLOOK DRIVE		20903	1			USA		
	Jeath	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. W	/as Decedent of h	lispanic Orig	gin? (Spe	ecify Yes or No-		Race · Ame	
٥	or Ite	교	Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼ No		Yes, specify Cub		, Puerto i	Hican, etc.)		Bfack, White	•
25	ral', c	b	3 XWidowed 4 □ Divorced If Yes, Give Year or Dates:		☐ Yes 2XNo	Specify:			Spe	ecify: Wt	IITE
21215-0036	72 h	etec	15. Decedent's Education 16 (Specify only highest grade completed)	(Give k	ent's Usual Occup	during most	of worki	ng i	16b. Kind o	of Business/	industry
7	hen.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		O NOT use retire	d)			OLIN	номе	
N	filed w Hygie other t		12 2	HOME	MAKER	18 Mothe	r's Name	(First, Middle,			
auc	d be filed antal Hyg and othe cevent,	Be c	CHARLES FRANCIS WILLIS			1		OODLAND			
Maryland	ges 1 and 2 should be filed within to f Health and Mental Hygiene. If item 27 Is marked other than or other traumatic event, Ite M.	ပ္	19a. Informant's Name/Relationship (Type, Print)		g Address (Street VERLOOK						
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tra ances.		1 FT Burial 2 Cremation 3 Permoval from State	tery, crem	ition (Name of atory or other pla ELD CEMI			7-2005		on · City or '	Town, State
att	permit. Departmine importa importa in in in in in in in in in in in in in		21. Signature of Funeral Service Licensee	22.	Name and Addre	ss of Facility	y TN C	MELINAM	PHME	DAT II	ME, P.A.
m —	2011		JOHN R. MERCERON	7 408	S. LIBI	ERTY S	T.,	CENTREV	ILLE,	MD 2	1617
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each fine.	o not ente	or the mode of dyi	ng, such as	cardiac c	or respiratory arr	est,		Approximate Interval Between Onset and Death
	Examiner ম	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury	e of):							
68760,	e be executed /sician and e burial-transit	cal Examin	that initiated events c	ce of):							
9	ificate ig physi as the l	led									
O. Box	ut the death certificate be by the attending physicia tached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death		Ectopic pregnanc Other (specify) _	у			23d.	Date of deli Month	ivery Day Year
ds, P.	juires that n signed b uld be deta	by	Part II. Other significant conditions contributing to death but not resulting	g in the un	derlying cause gr	ven in Part I.		23e. Did to		-	the cause of death?
Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed						24a. Was a autop: perfor	sy	4b. Were au prior to death?	topsy findings available completion of cause of
Viita		BeC	25. Was case referred to medical			26. Place	of Death	(Check only or			
<u>_</u>	d is	10.0	examiner? 1   Yes 2   No	Outpatient	d 3□ DOA Ot	ner: 4 Nu	irsing Ho	me 5□Resid	ence 6 🗆	Other (Spec	cify)
n of			27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28t	. Time of Injury	28c. inju Wo	ry at		28d. Describe h	ow injury oc	curred	
0	Attandia death. ctor: Al y the fu	catle	2 Accident investigation			Yes 2 🗆	No				
Division	or Attankater death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	, farm, stre	et, factory, office			28f. Location (S City or Tow		um <i>ber or R</i> u	iral Route Number,
	To the Hospital or Attanding within 24 hours after death. For the Funeral Director; After completely filled in by the fune	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	dge, death and/or inv	restigation, in my	opinion, dea	d place, th occurr	and due to the cred at the time, c	ause(s) and date and pla	d manner as	stated. to the cause(s)
}	Wind No.	2	29b. Signature and title of certifier  AD  M  I		29c. Licen	se number	17		1 6	gned (Mont	n. Day, Year)
	(1)		ROBERT SONCHEZ MD 508.2	DLE	WILD /	MINU	6	EAST	ON !	MO	21601
	St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Refistrar's Signature OCT 18 2005	× 16	food						
Di	MH 17 Ray 1/			-1						-	

DHMH 17 Rev 1/2001

		For State Registrar		State of	Marylar	nd / Depa	artme <i>rtifica</i>	nt of H	ealth a Death	ind M		Reg. N		5	352	
Physicia /Medic Examin	al	Decedent's Name (First, Middle 4a. Facility Name (If not institution)	n, give str	eet and num		en	-		Location of	- 17	2. Date of D Month	2	ay C. County			of Death
Funeral Director	×	5. Social Security Number  220-16-5808  Usual Residence of Decedent	6. Sex	Hosp		last birthday) Yrs.		er 1 Year	erla: If Under 2 Hours		8. Date of B (Month, D December	rth	r)	9. Birthp		or Foreign d
28e-f ehow	ector	10a. State 10b. County  Maryland	Allega	ny	10c. Ci	ty, Town or Lo			Midlar	ıd						City Limits
The first Strong to British while the first strong strong strong min from a year of the first strong	by Funeral Director	11. Marital Status	12	Armed Ford	ent Ever in U	I.S. 13.		ip Code edent of H	21542 spanic Orig n, Mexican,		ecify Yes or N Rican, etc.)		14. Rac	U.S.A e - Americ k, White,	an Indian,	
naturel', or l	eted by Fi	1 □ Never Married 2 □ Mar 3 🕅 Widowed 4 □ Divorced 15. Deceder (Specify only highe	it's Educa	1 XYes 2 If Yes, Give Year or Dat tion completed)		16a. Dece	dent's Us		Specify: ation during most	of work	na	16b.	Specify		White	
al Hygiene.	Be Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle,		College (1-0	4ar 5+)	life.	DO NOT	use retired	nspecto	r	e (First, Middle		n Surnam	10)	nistratio	on
eelth and Ment m 27 te marked ser treumatic d	To	19a. Informant's Name/Relations  John Cu	hip (Type		en	19b. Mailir					l al Route Numb Road, Fros	er, City		State, Zip		
Depertment of Heelth a important: If Item 27 Is any injury or other tre-		20a. Method of Disposition  1 X Burial 2 Cremation 4 Donation 5 Other (S	3 ⊟Rer Specify)	noval from S	ate	Place of Disponentery, cremetery, cremetery, cremetery.	sition (N natory or Is Cat	ame of other plac holic C	emetery	,	Oate October 26, 2005	20c. l	Location - Frost	City or To	wn, State Marylan	
Medical Medical kamine prival lumble prival	edicai Examiner	23a. Part I anter the disease, or shock or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	Due to (o	r as a consecurate as a	th. Do not ent  OH  [uence of):	er the mo	ode of dyin	Lo	onaco cardiac		yland Irrest,	1, 2153	9	Approximal Interval Be Onset and	ate etween
signed by the attending ph d be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	230	1 Live bir	ome of pregnath 2 ⊟Feta nt at time of co on	al death 3	Ectopic Other (	pregnancy specify)					23d. Date Mor	e of delive ath	ry Day	Year
After this certificete has been signed to funeral director, page 2 should be det	Completed by P	Part II. Other significant conditi	ons contri	buting to dea	th but not res	sulting in the u	nderlying	cause give	en in Part I.	_	1 24a. Wa:	Yes 2	2 🗆 No 24b. V	3 ☐ Prob	e cause of abity 4.50 abity 4.50 about 4.50 abity 4.50	onknown s available
Director: After this certifi in by the funeral director	Certification: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendia investi 2 Accident 3 Suicide 6 Could determ	ng gation not be	28a. Date of (Month)	Injury Day Year)	28b. Time of Injury	М	28c. Injury Work 1 🔲 '	er: 4 □ Nur	sing Ho	me 5 Res 28d. Describe	how inj	ury occurr	ed		m <i>ber,</i>
within 24 hours efter death.  To the Funerel Director: A completely filled in by the fu	Medical Cer	29a. Certifier (Check only one)  29b. Signature and title of certifie	Examine	rian: To the less and manne	is of exampha	owledge, death	vestigation 2	on, in my op 9c. License	number	h occurr	and due to the	cause( date ar	s) and ma nd place, a ate signed	and due to	the cause(	
VA	ite	30. Name and address of person DR. Vi Kramaco 31. Date filed (Month, Day, Year,	7:4,	19 9	of death (Iter	m 23a) (Type,	Print)	5 C	o76k Umber	ر -رم	D,M	D	2150	25-	2001	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Annie S. Cockrell October 12, 2005 8:55 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1713 CHESAPEAKE DRIVE **EDGEWATER** ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□м аДГ Director 68 574 12 8583 JULY 16,1937 ALASKA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f ahov item 27 is marked other than "natural", or itams 23a or 28a-f abov other treumatic event, the Medical Expirator invalves the notified at 1 Yes 2 No Director MARYLAND ANNE ARUNDEL **EDGEWATER** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1713 CHESAPEAKE DRIVE Completed by Funeral UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: if term 27 is marked other than "natural", or itam any injury or other treumatic event, the Medical Examples 2008. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 🙀 No Specify: 3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 ADMINISTRATIVE ASSISTANT A.A.CO. SCHOOLS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ္ဂ EDDIE SMITH MAGGIE KOTCHUTIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JACK T. COCKRELL (SON) 1713 CHESAPEAKE DRIVE EDGEWATER, MD. 21037 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State `4 □Donation 5 □ Other (Specify) KALAS CREMATORY EDGEWATER, MD. 10-16-05 21. Signature of Funeral Serv 22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME 2973 SOLOMONS ISLAND ROAD EDGEWATER, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** anches titis ONIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed for use as the burial-tran resulting in death) Last Due to (or as a consequence of): been signed by the attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 ☐ Yes 2 ☐ No 3 Probably nknown Enilon 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy certificate 1 Yes 1 Yes or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Certification: To I Other: 4 \sum Nursing Home 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) After this 27. Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury death. 1 Yes 2 No s after death Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

State Registrar (Check only one)

)61910A

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Messic

address of person who completed cause of death (Item 23a) (Type, Print)

2629

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

		For State Registrar	State of	of Marylar	nd / Depa	artment of I	Health and <i>Death</i>	d Mental Hyg	ieme 0 0 5	35277
		Decedent's Name (First, Middle	, Last)					2. Date of Dea	th	3. Time of Death
Physic /Med		Reginald				Clark .	Sr	October	Day Yea 12, 2005	5:06 P. M
Exam		4a. Facility Name (If not institution	give street and nu	ımber)			or Location of De		4c. County of De	
		Cherry Lane No	ırsing Ce	nter		Laure	1		Prince G	eorge!s
Funera	al		6. Sex	7. Age (In yrs.	. last birthday)		If Under 24 H	Irs. 8. Date of Birth In. (Month, Day	Vearl 9. B	irthplace (State or Foreign Country)
Directo	r	239-48-1008	1 <b>X</b> M 2□ F	74	Yrs.	Months Days	Hours W	1/6/31	Ha	lifax.N.C.
pu »		Usual Residence of Decedent  10a. State 10b. County		100 0	ity. Town or Lo					•
aryla shov	=	Tod. State Tob. County		100. 01	ity, Town or Lo	ocation				10d. Inside City Limits
Ne M	Director	D.C.			Was	hington				Yes 2 No
with t	듑	10e. Street and Number				10f. Zip Code	0040	1	0g. Citizen of What (	Country?
CLINISON  (Iled within 72 hours after deeth with the Maryland Hygiene.  the than "natural", or Items 23s or 28s-f show ant, It a Medical Examinar must be notified at	Funeral	624 50th St.,			10		0019		U.S.A.	
item	i,	11. Marital Status	Armed F	edent Ever in U		Was Decedent of If Yes, specify Cub	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)	Black, Wh	
rs aff	by F	1 ☐ Never Married 2√2 Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes, G	2 □ No ive	54	1☐ Yes 2√ No	Specify:		Specify: Af	
2-0036 72 hours af inatural; or dieal Exam	e	15. Decedent		Januar		dent's Usual Occu	nation		16b. Kind of Busines	erican
2 2 2	pet	(Specify only highes	t grade completed)		(Give	kind of work done DO NOT use retire	during most of v	working	TOD. TAILE OF BESITES	armoustry
I with	Completed	Elementary/Secondary (0-12)	Conege	1-4or 5+)	Do	mestic-F	ublic So	chools	D.C. Scho	ol System
Hygothe other	a)	17. Father's Name (First, Middle, I	ast)				18. Mother's N	lame (First, Middle, I		
land lid be filk fental Hy rked oth	To B	Cornelius	Clark				Ma	artha Smit	:h	
Maryland d 2 should be f th and Mental H T is marked of traumatic ever	-	19a. Informant's Name/Relationsh	ip (Турө, Print)		19b. Maili	ng Address (Stree	t and Number or	Rural Route Number	, City or Town, State	Zip Code)
alth a		Rosa Lee Clark/	Wife		624	50th St.	N.E. V	Washington	D.C. 20	019
DESIGNATION CE, MISTIGNA 212.15-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, Ite Modical Examinator must be notified at	1	20a. Method of Disposition		20b. I	Place of Dispo	osition (Name of matory or other pla	ice)		20c. Location - City of	r Town, State
Page Page Int: H		1 Burial 2 ☐ Cremation  '4 ☐ Donation 5 ☐ Other (Sp		State				k 10/22/05	Laurel.	Md.
SaltIMOF Sermit. Pages Department of mportant: If it iny injury or o	á	21. Signature of Funeral Service I	icensee							
	9000	arry	NE	nall	4	925 Burro	ington & oughs Av	Sons Co.	inc. Ashinaton.	D.C. 20019
- E 1 W.		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the dea	th. Do not en	ter the mode of dy	ing, such as card	liac or respiratory arre	est,	Approximate Interval Between
Physician	n	Immediate Cause (Final disease or condition			⊢iα ™hr	coat Canc	or			Onset and Death
/Medica	ıl	resulting in death)		(or as a consec		.oat Canc	ET			
Examine	r	Convention the line conditions	h							
7 -	ne i	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a consec	quence of):					
cuter	Examine	cause. Enter Underlying Cause (Disease or Injury that initiated events	c							
e exe		resulting in death) Last	Due to	(or as a consec	quence of):					
Certificate be executed reding physician and use as the burial-transit	dical		d							
artific ing p	Mec	IF FEMALE:								
GOLDS, P.O. BOX O wrequires that the death certific been signed by the attending p should be detached for use as	hysician/Me	23b. Was decedent pregnant in the past 12 months?		itcome of pregn birth 2 ☐ Feta		DEctopic pregnanc	:y		23d. Date of d	
e death the atten	200	1 ☐ Yes 2 ☐ No	4□Preg	nant at time of o		Other (specify)	·		Month	Day Year
requires that the seen signed by the hould be detached	Phy	9 Unknown								
igner	þ	Part II. Other significant conditio			sulting in the u	nderlying cause gr	ven in Part I.		_	to the cause of death?
negui nould	ted	Aspirati	on Pneum	onia				1 <b>4</b> Ye	es 2 No 3 F	Probably 4 Unknown
The law requires to the law requires to the law requires to the law age 2 should be considered.	Completed	Cerebral	Infarct					24a. Was ai	n 24b. Were a	tutopsy findings available completion of cause of
	ő							perforn	ned? death?	
VITAL iclan: T certificat ector, pa	Be	25. Was case referred to medical examiner?						eath (Check only on	9)	
OI VITA Physician: this certific ral director,	2	1 ☐ Yes 2 ☐ No			ER/Outpatier	nt 3□ DOA Ot	her: 4 Nursing	Home 5□ Reside	nce 6 Other (Sp	ecify)
Ing ing	e ::	27. Manner of Death  1 © Natural 5 Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time o Injury	f 28c. Inju Wo	ry at rk?	28d. Describe ho	w injury occurred	\
Attending r death.	cati	2 Accident investig	ation			M 1	Yes 2 □No			
JIVISION  or Attending after death.  Director: Afte	Certification:	4 Homicide determi	ned 286. Place	e of Injury - At h ing, etc. (Speci	ome, farm, str fy)	eet, factory, office		28f. Location (Sti	reet a <i>nd N</i> umber or F i, State)	Rural Route Number,
oitai urs a arai C	ပိ		+					1		
DIVISIO  To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1 Certifying (Check only one) 2 Madical E	:xaminer: On the b	asis of examina	owledge, deat ation and/or in	h occurred at the ti vestigation, in my	me, date and pla opinion, death oc	ice, and due to the ca	use(s) and manner a ate and place, and du	s stated. e to the cause(s)
o the ithin ; the imple	Med	29b. Signature and title of Lantijer	and mar	ner stated.		29c. Licens			d. Date signed (Mor	
F 3 F 8		10.1	M. At			Di	1225	ſ	1 1	un Day, Ical)
9 2		20 1/20	NXX		- 00-) -	1)07	220		0/13/05	
- 14	a	30. Name and address of person v		se of death (Iter			- Pal C	-A11-15	Callow DI	(MI) 20740
	itate	31. Date filed (Month, Day, Year)		Registrar's Signa		reenhelt	VCA) Q	we u	course y	1111/20140
Regis		OCT 1 8 2		ve &		100				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiepe0.0535278 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year LOUISE MARCELLE COLSON October 14, 2005 5:15\_p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Doctor's Community Hospital Prince George's Lanham 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1□M 2XF 79 Director 579-34-7593 July 18, 1926 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location r then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 X Yes 2 No Director Maryland Prince George's 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 13016 7th Street 20720 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Prince George's Elementary/Secondary (0-12) College (1-4or 5+) 12 Food Service County Schools permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 le marked oth eny jury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Harold Hayden Helen Merrill Rollins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1626 Branham Lane, Apt. 160, San Jose, CA 95118 Elwood J. Colson, Jr. - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ∑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery | 10/18/2005 | Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 ans HILL 23a. 9 nt. Inter the disease, or complications that studed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sich line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Se IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ŏ Month 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Pericardial Effusion 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s certificate has autopsy performed? 1 ☐ Yes 2 💢 No Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending Injury death. 1 Tes 2 No 2 Accident investigation after death 6 Could not be determined 3 Suicide Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C 29a, Certifier 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00159993

U D

State Registrar

Amirali Amjade, MD 31. Date filed (Month, Day, Year) OCT 1 8 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8118 Good Luck Road, Lanham, Maryland 20706
2. Registrar's Signature

			For State Registrar		State	of Mary	rland / Dep <i>Ce</i>	artmer ertificat	nt of H	ealth a	and M		giene Reg. No		352	79
	Physici	an	1. Decedent's Name									2. Date of De Month	ath Da	y Year	3. Time of	Death
	/Medic	al	Mabel J			umbarl		4h City	Town or	Location of		October		2005 County of Deat	5:15	_ P <sup>™</sup> _
	Examin	er	4a. Facility Name (# r 25 Brack			umberj			ng Si		or Dodair			Cecil		
	Funeral		5. Social Security Nur	mber 6.	Sex		yrs. last birthday		r 1 Year	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da	th	9. Birtl	nplace (State o	r Foreign
	Director		219-28-40		1□M <b>¾</b> □F	78	Yrs.	Wiemans	ou, o					927 West		nia
	land		Usual Residence of E 10a. State	10b. County		10	c. City, Town or L	ocation							10d. Inside Ci	ty Limits
	Mary a-f sh	to	Maryland	Cecil			Rising	Sun							1 ☐ Yes	<b>¾</b> □ No
	h with the 23e or 28e	Funerai Director	10e. Street and Numl 41 Bracki					1 1	p Code 911					tizen of What Co ed State		
36	4 within 72 hours after death with the Maryland jiene. Ir then "neturel", or Items 23e or 28e-f show the Madical Examinar must be motified at	by Funer	11. Marital Status		12. Was De Armed I 1Yes If Yes, O Year or	Forces?	r in U.S. 13.	Was Oece If Yes, spe	cify Cuba	spanic Ori n, Mexicar Specify:	i, Puerto	ecify Yes or No Rican, etc.)	)-	14. Race - Ame Black, White Specify: Wh 1	e, etc.	
21215-0036	2 hours	ted b		5. Decedent's	Education			edent's Usu			t of worki	na	16b. K	(ind of Business/	Industry	-
218	within 7 lene. then "n	Completed	Elementary/Secon	y only highest g dary (0-12)		(1-4or 5+)	life.	DO NOT L	ise retired	)	i di worki	ng				
121	e filed w Il Hygier other th		17. Father's Name (F	irst Middle I a	st)		Homem	aker	1	18. Mothe	er's Name	(First, Middle		Home		
anc	ould be fi Mental H karked ot	o Be	Jesse Yate		31/					Susa			,	· oumano,		
Maryland	s 1 and 2 should be filed f Health and Mental Hyg item 27 is marked othe other treumatic event,	ပ	19a. Informant's Nar		(Type, Print)		19b. Mai	ling Addres	s (Street a				er, City	or Town, State, Z	lip Code)	
	and 2 ealth a m 27 is		Mary Wagne	r / Sis	ter		P.O.	Box	411,	Nort	h Ea	st, Mar	ylaı	nd 21901		
Baltimore,	Pages 1 and 2 nent of Health int: If item 27 inty or other tre		20a. Method of Dispo 1 Burial 2 Donation	Cremation 3	□Removal from	m State	20b. Place of Disp cemetery, cri Harford Garde	ematory or Memor	other plac	ө) O		•		rdeen, M		d
Balti	permit. Pages Department of Importent: If it eny injury or once.		21. Signal 1976	ervice L	ensee			22. Name a				uch Fur t, Nort		l Home ast, Mar	yland :	21901
	Physician /Medical		23a Parth. Ester the shock, or heart Immediate Cause (F disease or condition resulting in death)	failure. List on	ly one cause or	each line.	onsequence ):			g, such as		or respiratory a	rrest,		Approximat Interval Bet Onset and (	ween
8760,	death certificate be executed be attending physician and add for use as the burial-transit	dical Examiner	Sequentially list con if any, leading to imreause. Enter Under Cause (Ulscass or international transition of the country resulting in death) La		c		onsequence of):									
.O. Box 68	at the death certificate by the attending phys tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 n 1 □ Yes 2 □ 9 □ Unknown	nonths?		e birth 2 [ gnant at tim	Fetal death 3	□Ectopic p						23d. Date of deli Month		Year
<u>α</u>	uires that t i signed by Id be detai	by	Part II. Other signific	cant conditions	s contributing to	death but n	ot resulting in the	undertying	cause give	en in Part I		23e. Did	_	use contribute to	the cause of dobably 4 🗆	
Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed										24a. Was auto perfo 1 ∐ Yes		death?	topsy findings completion of c	available ause of
Vital	ysicien: Th is certificate director, paq	BeC	25. Was case referre	ed to medical	15				Lau			(Check only				
of V	Physicien: this certific ral director,	2	1 ☐ Yes 2 ☑	16		Inpatient	2 ER/Outpati					me 5 Resi 28d. Describe		6 NOther (Special	ster's	
	ding T. After fune	tlon	27. Manner of Death	5 Pending		te of Injury o <i>nth, Day</i> Yo	ear) 28b. Time Injury	M	28c. Injun Work	k? Yes 2. □		200. Describe	now and	ary occurred		
Division	l or Attendi after death. Director: A I in by the fu	Certification:	2 Accident 3 Suicide 4 Homicide	6 Could not determine	be 28e. Pla	ice of Injury Ilding, etc. (	- At home, farm, s Specify)					28f. Location ( City or To	Street a wn, Stat	nd Number or Ru e)	ıral Route Num	iber,
_	ospite hours unerel ly fillec	edicai C	29a. Certifier (Check only one)	1 Certifying 2 Medical Ex	aminer: On the	the best of n basis of ex anner stated	ny knowledge, des amination and/or d.	ath occurred investigatio	d at the tin	ne, date ar pinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s	s) and manner as nd place, and due	stated. to the cause(s	;)
	To the H within 24 To the Fi complete	Me	29b. Signature, and	itle of certifier			iM	7	oc. Licens	e number	64	49	29d. Da	ate signed (Mortu	n, Day, Year)	
	H		3. Name and address	es of person wh	son M	D 11	1 West	Print)	St	Si	le :	302	Ell	Klank	1D 21	1921
	St Regist	ate rar	31. Date filed (Mont.	8 2005	ken 32	. Registrar's	Signature	,								

			For State Registrar	State of	f Maryland		artment of He rtificate of D			jierze ()	5 35280	
ì	Physici		1. Decedent's Name (First, Middle Antrim	, Last) W.	Chandle	r			2. Date of Dea Month	Day	Year 3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution, Philosula Reniam	give street and num	nber)	ter	4b. City, Town, or L	ocation of Death		4c. County		
	Funeral Director		5. Social Security Number 171–10–1881	6. Sex 1 XM 2 ☐ F	7. Age (In yrs. ld 92	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 5/27/11	, Year)	Birthplace (State or Foreign Country)  Pennsylvania	
	aryland ehow	70	Usual Residence of Decedent  10a. State 10b. County	D-1		, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2€ No	
	with the M a or 28a-f be notifie	Director	Pennsylvania  10e. Street and Number  3131 Meetingh	Delaware		oothwy	7n 10f. Zip Code 19061		1	10g. Citizen of V USA		
0000	2 should be tiled within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f ehow aumatic avant, the Medical Evantiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Marri 3 XWidowed 4 Divorced	12. Was Dece Armed Fo	edent Ever in U.S rces? 2 [XNo		Was Decedent of His f Yes, specify Cuban	panic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Blace	e - American Indian, ck, White, etc.	_
20-612	ithin 72 hou le. len "natura Medical E	Completed !	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education		(Give life.	dent's Usual Occupati kind of work done du DO NOT use retired)	ring most of work	ing	16b. Kind of Bu	usiness/Industry	
and 21		Be	12 17. Father's Name (First, Middle, I William H. Cha		adiation.	Super	rvisor/cus		e (First, Middle, a	Collect		
Mary	4434	To	19a. Informant's Name/Relationsh William H. Char		orother		ng Address <i>(Street ar</i> L Meetingh				State, Zip Code) , PA 19061	
nore,	ages 1 and int of Health t: If itam 27 y or othar tr		20a. Method of Disposition  1  Burial 2  Cremation  4  Donation 5  Other (Sp.	3 □Removal from	State 20b. Pt	ace of Dispo emetery, crer	sition (Name of natory or other place)		Date	20c. Location -	City or Town, State	
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	Pnysician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on e	aused the death	. Do not ent					Approximate Interval Between Onset and Death	
	Examiner	ıer	Sequentially list conditions, if any, leading to immediate course for the elying Cause (Disease or injury	b. Fa	eluse (or as a consequ		to thri	ve				
8/60,	death certificate be executed e attending physician and of for use as the buriat-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(+F) (or as a consequ	rence of):						
O. BOX 68	he death certifica / the attending ph ched for use as th	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1☐Live b	tcome of pregnat pirth 2 Tetal pant at time of de pwn	death 3	Ectopic pregnancy Other (specify)			23d. Dat Mor	te of delivery nnth Day Year	
ds, P.	w requires that the de been signed by the should be detached	d by Physicl	Part II. Other significant condition	ns contributing to de	eath but not resu	ilting in the u	nderlying cause giver	in Part I.			ribute to the cause of death?	
II Records,	The lar ate has page 2	Completed							24a. Was a autops perform	med? o	Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No	
VItal	cian: sertific ector,	Be	25. Was case referred to medical examiner?	Magnitol	4				h (Check only on			_
0	ing Phy J. After this funeral d	tlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendin 2 Accident investic	28a. Date (Moni		ER/Outpatier 28b. Time o Injury	28c. Injury a Work?	at	ome 5 Reside			
DIVISION	To the Hospital or Attanding within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investig 3 Suicide 6 Could r 4 Homicide determ	not be 28e. Place	of Injury - At hoing, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Si City or Town	treet and Numbe n, State)	er or Rural Route Number,	
	Fo the Hospit: within 24 hours Fo the Funare	g	(Check only 2 Medical I	Evaminar: On the h	acie of evaminat	ion and/or in	n occurred at the time vestigation, in my opin	nion doath occur	rad at the time d	ato and place of	and due to the source(a)	
	To the To the	Σ	29b. Signature and title of certifier  30. Name and address of person  31. Date filed (Month, Day Year)	y.D.			29c. License	795 2	2	9d. Date signed	6 / 2005	
1	5 IM		30. Name and address of person	who completed caus	se of death (Item	23a) (Type,	Print) 7 # 504	-B , Sas	lis bary	MD	21804	
	Sta Registr	ite ar	31. Date filed (Month Day Year)	9 2005 32.	egistrar's Signar	b. A	barle					

State of Maryland / Department of Health and Mental Hygien 05 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Yeer **Physician** 2005 readore /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carri tome If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1X M 2□ F -12-0 Director Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 No MI Wicomic Sherve Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S. K Completed by Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: In Kraum 1 Never Married 2 Married Specify: B/ACK 1 ☐ Yes 2 ☐ No 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry / Elementary/Secondary (0-12) College (1-4or 5+) Tarker Duck ( ard Mon with grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Collins 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 600 Salishary and 2180 Cla 57 SUNI 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 120/05 \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility - Salsburg md 21861 W. Isabella st Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) -alure Ren Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of) Examiner HF C the attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ofi Physician/Medical 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No nemia Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed After this certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death or Attanding 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Sampletely filled in by 4 Homicide within 24 hours of To the Funerel 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D57952 504B Salibum 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 57. at Miltord Ty J 106 32. Figistrar's Signature 31. Date filed (Month, Day, Year)
OCT 1 8 2005 Registrar

		•	For State Registrar		State o	f Marylar	nd / Depa <i>Cer</i>	irtment of <i>tificate o</i>	Healt f Dea	th and M ath	1ental Hy	giene Reg. No.	005	35282
	at the m	45	Decedent's Name (First,	Middle, Last)							2. Date of De Month		V	3. Time of Death
	Physicia		ORBIN JULLI	AN DEA	NE. II	I					10	Day <b>14</b>	Year 05	4:49 PM
1 30	Medical Examiner  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Local											4c.	County of Dea	
	Washington Adventist Hospital Takoma Park									k. MD		М	ontgome	erv
3.	Funeral		5. Social Security Number	6. Sex	0100	7. Age (In yrs.	last birthday)	If Under 1 Ye Months Day	ar If Ur	nder 24 Hrs.	8. Date of Bi (Month, D	rth ay, Year)	9. Bir	thplace (State or Foreign ountry)
	Director	8	231-44-4988	124	M 2□F	69	Yrs.				06-0			rginia
	D .		Usual Residence of Deceder 10a, State 10b, C			10c Ci	ty, Town or Lo	nation			`			10d. Inside City Limits
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	or 2	Director	10e. Street and Number			"05		10f. Zip Cod					zen of What C	ountry ?
	ath v	<u>ea</u>	8601 Temple					2074		0::0/0			US 14. Race - Am	rines Indias
	72 hours after death with the Maryland Inatural', or Items 23a or 28a-f show digal Extendinet must be neillied at	Funeral	11. Marital Status		Armed Fo		J.S. 13. 1	Was Decedent of f Yes, specify C	uban, Me	xican, Puerto	Rican, etc.)	0-	Black, Whi	
36	s afti	by F	1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Div	-	1 XYes If Yes, Gi	ve pates: 54-7	'7	1 ☐ Yes 2 🏋	No Spe	ecify:			Specify:	lack
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12	within ene.	E C	Elementary/Secondary (	)-12)	College (		Toc	hnical 1	Mri+c	25		Ger	neral D	ynamics
9	Hygin Hygin ant,		17. Father's Name (First, N	liddle, Last)	<u> </u>	COLS	160	шисал			e (First, Middle	e, Maiden	Sumame)	
an	id be entai	To Be	Orbin J. De	ane, Ji	c.				Т	orine	Johnso	m		
Baltimore, Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or liems 23a or 28a-1 show or other traumatic event, the Macical Exeminer must be notified at	-	19a. Informant's Name/Re				19b. Mailir	ng Address (Stre					Town, State,	Zip Code)
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ē,	permit. Pages 1 and Department of Heali Important: if itsm 2 any injury or other gncs.		20a. Method of Disposition				Place of Dispo	sition (Name of natory or other)			Date		cation - City or	
0	ages ont of t: if i	- 53	1 ☑ Burial 2 ☐ Crem 4 ☐ Donation 5 ☐ Of	ation 3 DR	emoval from	State		nal Cem		10/	21/05	Chol	According to	MES
Ħ	artme srtan ortan injur		21. Signature of Funeral S		θ _			Name and Ad	-	- Contilibra			tenham	•
Ba	Depa Impo any i		A. 11	X	-16	()				St	rickla	nd Fu	neral S	Services
	A .	$\vdash$	23a. Part1. Enter the disea	ise, or compli	cations that	caused the dea	th. Do not ent	er the mode of	tying, suc	n RO, C	or respiratory	rings arrest,	, MD	20748 Approximate
			shock, or heart failure Immediate Cause (Final	. List only on	e cause on	each line.	11.0	1-000		1000	2			Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	a		77-11	) ruen	NOMA	1 1	YLC.	7			
	Examiner		•		Due to	or as a conse	quence of):	NEA	00-	TIMO				
1.		-	Sequentially list conditions	b b	Due to	(or as a conse	quence of):	(10) 11	AC.	11017		-		
	ted nsit	Examine	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury	<	Dri	ARCTO	e 1	nelli	Tuc					
	xecu and al-tra	xar	that initiated events resulting in death) Last	C	Due to	(or as a conse	_ ,	110001	1 93					
8760,	the death certificate be executed y the ettending physician and sched for use as the burial-transit	alE			Se	FTICE	MIA							
687	icate phys	edical												
	eath certific ettending p I for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregna	ant 2		tcome of pregn						2	23d. Date of de	elivery
Вох	etter for u	ciai	in the past 12 months 1 Yes 2 No			birth 2∏Fet nant at time of		∃Ectopic pregna ∃Other (s <i>pecify</i>					Month	Day Year
o.	at the de by the tached	ysi	9 Unknown		9□ Unkr	nown								
Q.	\$ 5 g		Part II. Other significant c	onditions con	tributing to o	leath but not re	sulting in the u	nderlying cause	given in F	Part I.	23e. Did	tobacco u	se contribute l	o the cause of death?
gp.	uires n sign ld be	d by									1□	Yes 2	9 No 3 □ P	robably 4 Unknown
Vital Records,	w requir been si should	Completed									24a. Wa	s an	24b. Were a	utopsy findings available
Re	The lar	E D									_ per	opsy formed?	death?	completion of cause of
G		ပိ	25. Was case referred to r	nodical					00.1	Otago of Dag	1 ☐ Yes th (Check only		1 L Ye	s 2☑No
⋚	Physician: this certific ral director,	o Be	examiner?		lospital:	Inpatient 2	☐ ER/Outpatier	nt 3 DOA	Othor		ome 5⊟Res		S ∏Other (Sp.	acufu)
of			27. Manner of Death		-	of Injury oth, Day Year)	28b. Time o	f 28c. I	njury at		28d. Describe			outy)
on	ding th. After funer	ţ.		Pending Investigation	(Moi	nth, Day Year)	Injury		Work? I∐Yes	2 □No				
Division	Attending r death. ector: After by the fune	Certification;	3 Suicide 6	Could not be determined	28e. Plac	e of Injury - At I	home, farm, st	reet, factory, off	сө		28f. Location	(Street and	d Number or F	Rural Route Number,
S	after Dire	erti	4  Homicide	30.011111100	build	ling, etc. (Spec	ufy)				City or 1	own, State,	)	
-	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th		29a Conflict 1_CC	ertifying Phys	delan: To th	a bast of my kn	rowledge, deat	h occurse at th	e time, da	ita and place	and due to the	a causc(s)	and manner a	s stated
	• Ho • Fur	Medical	(Check only 2 Moone)	edical Examin	ner: On the I	pasis of examination of states.	ation and/or in	vestigation, in n	ny opinion	n, death occur	rred at the time	, date and	place, and du	e to the cause(s)
	rc th Vithin Io th	Me	29b. Signature and title of	certifier				29c. Lic	ense num	nber		29d. Dat	e signed (Mon	ith, Day, Year)
	,- > - 0		1 Trove	nolle	M			100	POS	29		OCTO	BCR 1	7 2005
0	/2)		30. Name and address of	person who co	mpleted cau	se of death (Ite	om 23a) (Type.	Print)				-10	V - V	
1	0		VICTOR (	DNYE	SIARA	730	LSA H	ASTOVER	PAS	ZKWAY	GREE	olbel	7 MAR	ILAND DOJOS
	St	ate	31. Date filed (Month, Day		2	Registrar's Sign		-			4			
	Regist		OCT 1	9 2005	Ella	uc d	Los	de)						

			For State Registrar	State of	f Marylai	nd / Depa <i>Ce</i>	artme <i>rtifica</i>	nt of H <i>te of L</i>	ealth and Death	Me.		iene2 ()	05	35283
	Dhusiai		1. Decedent's Name (First, Middle, Las	t)							Date of Deat Month		Year	3. Time of Death
	Physici /Medic		Lucille W. Evar	S						0	ctober	14, 2	005 <sup>ar</sup>	1:45 P M
	Examin	er	4a. Facility Name (If not institution, give		nber)				Location of De	ath			y of Death	
			Suburban Hospita 5. Social Security Number 6. Se		7. Age (In yrs.	lact hirthday)		hesd	a If Under 24 H	rs. 8	Date of Birth	Mon	tgome	
	Funeral Director			M 2F	94	Yrs.	Months		Hours Mi	in.	(Month, Dey, uly 23		Cou	place (State or Foreign ntry) ginia
			Usual Residence of Decedent	1						10	ury 23	, 1711	1 411	ginia
	nylan how		10a. State 10b. County			ity, Town or Lo								10d. Inside City Limits
	9 Ma	cto	D.C. N/A		Wa	shingt	on				.,_			1 ⊈Yes 2 □ No
	ih th or 21	Dire	10e. Street and Number					p Code			1	0g. Citizen of	What Cou	ntry?
	ath v	rai	1300 Somerset Pla		CAE TO A	10 10		)11				United		
21215-0036	n 72 hours after death with the Maryland "natural", or Iteme 23e or 28e-1 ehow adical Estaninar must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Dece Armed Fo 1  Yes If Yes, Giv Year or D	2 <b>□</b> No e		Was Dec If Yes, sp 1  Yes	ecify Cubai	spanic Origin? n, Mexican, Pu Specify:	(Specifi erto Ric	y Yes or No- an, etc.)		ack, White,	can Indian, etc. ack
Ö	2 2 3	Completed	15. Decedent's Ed (Specify only highest gra			16a. Dece	dent's Us	al Occupa	ation during most of w	work in a		16b. Kind of E	Business/Ir	ndustry
7	within ? ene. then "r	npie	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT	use retired,	)	*U/K/IIIg				
7	Hygien Hygien ther th	ပ်		5+		Teac	her	1				Educa		
Ē	a la p ≥	Be	17. Father's Name (First, Middle, Last) Richard P. William	16					18. Mother's N			Maiden Suma	me)	
<u> </u>	d Menid	٩	19a. Informant's Name/Relationship (7			10h Maili	an Addra	o (Ctroot o	and Number or			Cit. or Tour	Cana 7	- 0- 1-1
Z	d 2 s th an t7 is r		Roscoe Evans	(Son	)	1	•		P1. N.			ngton,		20011
ō,	1 and Heeli tem 2 other		20a. Method of Disposition	(BOIL	20b.	Place of Dispo	sition (Na	me of	- T	Date	_	20c. Location		
2	THE INTERIOR		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify			cemetery, crei				/20				Maryland
Baltimore,	ortan Injur	1	21. Signature of Funeral Service Licen						s of FacilityMc		83			
Ba	permit. Pages 1 and 2 should Department of Heelth and Mel Important: If Item 27 Is mark any Injury of other traumatic once.		Thomas M	Clyb	win	7	400	Georg	ia Ave.	Ν.	W., Wa	shingt		.C. 20012
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Seps	ach line.	ur. Do not en	er the mic	ae or aying	g, such as card	iac or n	aspiratory arre	ist,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)		or as a conse									
		٦.	Sequentially list conditions,		Stage		Failu	re						
	pet nsit	Examiner	cause. Enter Underlying Cause (Disease or injury		Stage		Di ao							
	al-tra	xar	that initiated events resulting in death) Last	U	or as a conse		DISE	156					-	
68760,	cate be executed physicien and the burial-transit	dicai	(	d. Stro	ke									
		Jed	IF FEMALE:									1	1	
Вох	death certifi e ettending id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, out 1 ☐ Live b	come of pregn inth 2 ☐ Fet	al death 3[		pregnancy					ate of deliv	ery Day Year
o.	0 0	/sici	1 Yes 2 No 9 Unknown	4□Pregn 9□Unkno	ant at time of	death 5	Other (s	pecify)					Ontri	Day 18a
Δ,	that thed by	P <sub>P</sub>	Part II. Other significant conditions of	ontributing to de	eath but not re	sulting in the u	nderlying	Callea Civa	on in Part I		23e Did toh	acco use con	ntribute to t	he cause of death?
Vital Records,	sign d be	d by					, aony ang	ousse give				s 2 \( \text{No} \)	3 ☐ Prol	
Ö	w requ	ete								- i	04- 145-	0.0		
Ř	The lav	Completed								-	24a. Was ar autops perform	/	prior to co death?	ppsy findings available impletion of cause of
		ပို	25. Was case referred to medical								1 ☐ Yes 2	⊠ No	1 Yes	2 No
₹	Physicien: rthis certific ral director,	o B	examiner?	Hospital:	npatient 2	TER/Outpation	nt 3 🗆 🖸	Othe	26. Place of D		5 ☐ Reside		has (C-10)	E.A
	g Phy er this eral c	H-	27. Manner of Death	28a. Date	of Injury	28b. Time o		28c. Injury Work			I. Describe ho			у/
ö	Attending I ir death. ector: After by the funer	atio	1 Accident 5 Pending 2 Accident investigation	(Mont	h, Day Year)	Injury	м		r ∕es 2 □ No					
É	257	Certification:	3 ☐ Surcide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place	of Injury - At I	nome, farm, str ify)	eet, facto	ry, office		281	Location (Str City or Town	reet and Num , State)	ber or Rur	al Route Number,
	Hospit 4 hour Funer tely fills	ledicai C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	I <b>Iner:</b> On the bi	best of my kn asis of examin ner stated.	owledge, deat ation and/or in	h occurre vestigatio	d at the tim	e, date and pla pinion, death oc	ce, and	due to the ca at the time, da	use(s) and m ite and place,	anner as s , and due t	tated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29	c. License	number		29	d. Date sign	ed (Month,	Day, Year)
	10		DATUA			ma	I	0063	195			ctober	14.	2005
	( )		30. Name and address of person who	completed caus	e of death (Ite	m 23a) (Type,						220001	,	
			Steven Wilks, M.	D. 470	00 MOrg	an Dri	ve, (	hevy	Chase,	MD	20815	i		
	Sta Registr		31. Date filed (Month, Day, Year)	113	egistrar's Sign	ature	de la							

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EVANOS, LUCILLE

		-	For State Registrar	State of M	arylan			t of Hea e <i>of De</i>		Mental	Hygien Reg. N	600	35284
F.	Physicia		1. Decedent's Name (First, Middle, La				CAN	En		Mon	of Death	ay Year	3. Time of Death
	/Medic	al -	POBERT  4a. Facility Name (If not institution, given	re street and number)			4h City	- 1	cation of Deat		ober	c. County of Deat	- 1841 M
	Examin	er	The Isharto	dine He	soite	(	Rob	Himor	e Ci	4		,	
	Funeral Director			9x 7. Ag 1 <b>X</b> M 2□ F	e vin yrs. I. 52	ast birthday) Yrs.	onths Worths		Under 24 Hrs lours Min.		of Birth Th Day Yea	<sup>r)</sup> 1953 9. Birt	nplace (State or Foreign Unitry) Maryland
	p		Usual Residence of Decedent  10a. State 10b. County		10c Cib	, Town or Lo	nation						10d. Inside City Limits
	Marylan a-f show	ctor	Maryland Talk	ot	Too. Oily	, TOWIT OF EC		1 Oak					1 ☐ Yes 2 🔀 No
	h with the	at Dire	10e. Street and Number 5442 Ferry Neck	Road			10f. Zip		21662		10g. 0	Citizen of What Co U.S	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avant. It is Madical Exactinat must be notified at ODGe.	by Fur	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			Was Decedif Yes, spec		nic Origin? (S Mexican, Puer Specify:	pecify Yes to Rican, e	or No-	14. Race - Ame Black, White Specify: W	
5-0	72 ho	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)		(Give	kind of wor	l Occupation	ng most of wo	rking	16b.	Kind of Business/	Industry
21215-0036	d within giene. ir than "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		oo not us il Se					County G	overnment
Maryland	uld be filed fental Hyg rkad otha fic avant,	To Be C	17. Father's Name (First, Middle, Las Edward Easter	1)				18.	Mother's Nat Eliz		Middle, Maide n Dors		
Mary	d 2 shouth and No. 7 is maintained		19a. Informant's Name/Relationship Fran Easter/wif				-				_	or Town, State, 2 Maryland	
	f Heali tam 2 othar		20a. Method of Disposition		20b. P	lace of Dispo				Date		Location - City or	
E	Page: nent of nt; If i		1 ☐ Burial 2 <b>XX</b> remation 3 [			ltimor			y   10,	/17/20	005 в	altimore	, Maryland
Baltimore,	permit. Departri Importa any inju		21. Signatur Funeral Service Lice	nsee E X	ill							or Funera nnapolis	al Home , MD 21401
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	nplications that cause one cause on each l	d the death	n. Do not ent	ter the mod	e of dying, s	uch as cardia	c or respira	atory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	w		Liver	DISEA	se					3 weeks
	/Medical Examiner		1	Due to (or as	a consequent	,							Dugar
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as									10 Cleves
	cuted nd ransit	amir	that initiated events	C									
90,	certificate be executed rding physician and ise as the burial-transit	ical Examiner	resulting in death) Last	Due to (or as	a consequ	uence of):							
8760,	physic	77	•	d									
O. Box 6	atter for L	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	Ideath 3□	∃Ectopic pr ∃ Other (sp					23d. Date of del Month	very Day Year
, P.O.	that the de ned by the detached	by Ph	Part II. Other significant conditions	contributing to death t	out not resi	ulting in the u	nderlying c	ause given ir	n Part I.	236	. Did tobacco	use contribute to	the cause of death?
rds	w requires that s been signed b should be deta	ed b									1 🗌 Yes	2□No 3□Pr	obably 4 Minknown
Records,	e ta has je 2	Completed							· · · · · ·		u. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of 2 No
Vital	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?						6. Place of De	ath (Check	only one)		
of \	phys this al di	10	1 Tes 2 No	Hospital: 1 Inpati		ER/Outpatier	-		4 Nursing F		Residence	6 Other (Specially occurred	cify)
on	of the state of th	tlon	1 Natural 5 Pending 2 Accident investigate	(Month, Da	y Year)	Injury	M	8c. Injury at Work? 1  Yes	2 🗆 No	200. Des	SCILDE NOW III	lary occarred	
Division	l or Attanding atter death. Diractor: After I in by the fune	Certification:	3 Suicide 6 Could not 4 Homicide determine	be One Bleen of le	jury - At ho tc. (Specify	ome, farm, st	reet, factory	, office			ation (Street or Town, Sta		ral Route Number,
_	To the Hospital or Attandi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the fr	edical C	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa	hysician: To the best iminer: On the basis of and manner s	of examina	wledge, deat tion and/or in	h occurred ivestigation	at the time, o	date and place on, death occ	e, and due urred at the	to the cause time, date a	(s) and manner as ind place, and due	stated. to the cause(s)
	To the within 2 To tha comple	Me	29b. Signature and title of certifier					. License nu			29d. [	Date signed (Monti	h. Day, Year)
				- MEDI	LAL	DOCTOR	2_	RES	-000	)	0	CTOBER	11 2005
			30. Name and address of person who RUPAL MARANI, JO	HHS HOPKIN	S HOSP	TAL, 6		27H n	DIFEST	RE47	r, BALTI	MORE, MO	21287
	Sta Regist		31. Date filed (Month, Day, Year)	32. P sist	rar's Signa	ture							

			For State Registrar	State of Maryl	and / Depa	artment of Health a rtificate of Death	ind Mental H	ygierne 05	35285
	Dhysiai		1. Decedent's Name (First, Middle, Last,				2. Date of I	Day Yea	3. Time of Death
F,	Physicia /Medic		Paul Nelson Edw				Oct.		
	Examin	er	4a. Facility Name (If not institution, give 3195 Elsa Ave.	street and number)		4b. City, Town, or Location of Waldorf	f Death	4c. County of D	
	Funoral		5. Social Security Number 6. Se:	x 7. Age (In)	rs. last birthday)	If Under 1 Year If Under 2	24 Hrs. 8. Date of I	Birth 9	Birthplace (State or Foreign Country)
п	Funeral Director			<sup>2M 2□F</sup> 94	Yrs.	Months Days Hours	Min. (Month, April	Day, Year) 3,1911	Iowa
	p ,		Usual Residence of Decedent  10a. State 10b. County	100	City. Town or Lo	cation			10d. Inside City Limits
	Aaryla I ahov	ō	Maryland Charl		Waldor				1 ☐ Yes 2 ☐ No
	28a-i	rect	10e. Street and Number		Waldol	10f. Zip Code		10g. Citizen of What	Country?
	ath with the Marylar 23e or 28a-f show		3195 Elsa Ave.			20603		U.S.A.	
	death	Funeral Directo	11. Marital Status	12. Was Decedent Ever i	n U.S. 13.	Was Decedent of Hispanic Orig f Yes, specify Cuban, Mexican	gin? (Specify Yes or i	No- 14. Race - A Black, W	merican Indian, /hite. etc.
36	or It	by Fu	1 Never Married 2 Marned 3 Widowed 4 Divorced	1 TYYes 2 □ No If Yes, Give		1 ☐ Yes 2 ☑ No Specify:		Specify: W	
Ö	be filed within 72 hours after death with the Maryland tal Hygiene.  do ther than "natural", or items 23a or 28a-f show about, the Madical Evertities I and be notified at	ed b	15. Decedent's Edu	Year or Dates:	16a. Dece	dent's Usual Occupation		16b. Kind of Busine	
15	nin 72 In "na Madis	Completed	(Specify only highest grad	e completed) College (1-4or 5+)	(Give	kind of work done during most DO NOT use retired)	of working		,
212	d with	mo:	12		Engir	neer		U.S. Gov	rernment
D	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)	2				tle, Maiden Surname)	
<u>Z</u>	should be and Mental se marked o	우	Lyman Edwar  19a. Informant's Name/Relationship (T)		10h Maili	Hu ng Address (Street and Number	lda	abor City or Town Stat	a Zin Coda)
Maryland 21215-0036	d 2 sl th and t7 is r traur		Geraldine B. Ed	lwards Wif	e 3195	Elsa Ave	Waldorf		
ē,	s 1 and f Health item 27 othar t		20a. Method of Disposition	20	b. Place of Dispo	esition (Name of matory or other place)	Date	20c. Location - City	
altimore,	Pages nent of int: If its ury or o		1 X Burial 2 ☐ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	ort Lir	coln Cemete	18,2005 ry	Brentwoo	d, Maryland
Balti	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic 900.9.		21. Signature of Funeral Service Licens		0668 Z	Name and Address of Facility Villiams Fund 1270 Hawthor	eral Hom	e, P.A.	20640
	*		23a. Part1. Enter the disease, or compi shock, or heart failure. List only o	lications that caused the d		er the mode of dying, such as	cardiac or respiratory	arrest,	Approximate fnterval Between
e,	Physician		fmmediate Cause (Final disease or condition		aech	ve Itea	xt fai	Jelle	Onset and Death
	/Medical		resulting in death)	Due to (or as a con	equence of):				
-94	Examiner	_	Sequentially list conditions, if any, reading to immediate	b. Due to (or as a con	manusana offe				
	ted nsit	Examiner	Cause (Disease or injury	D00 10 (01 01 0 00)	ecquain a oi).				
,	execun n and ial-tra	Exar	that initiated events resulting in death) Last	c.  Due to (or as a con	sequence of):				
8760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	ical		d			·		
9	ing ph	Med	IF FEMALE:	20-14					
Вох	eath certific attending p	Physician/M	in the past 12 months?	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time	etal death 3	Ectopic pregnancy Other (specify)		23d. Date of Month	delivery Day Year
o.	y the iched	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	51 35uii				
<b>a</b>	res that the designed by the a	by Pł	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	nderlying cause given in Part I.	23e. Di	d tobacco use contribute	e to the cause of death?
Records,	w require been sig should b						1[	]Yes 2□No 3□	Probably 4 DUnknown
ecc	e law re has be je 2 sho	Completed						topsy prior	autopsy findings available to completion of cause of
	The cate h	Con					pe 1 ☐ Yes	rformed? death	
Vital	Physician: The ribis certificate hiral director, page	Be	25. Was case referred to medical examiner?	Hospital:		Othor	of Death (Check onl		
of	Phys r this ral dii	1: To	1 Yes 2 No	1 ☐ Inpatient  28a. Date of fnjury (Month, Day Yea	2 ER/Outpaties 28b. Time o	IL 30 DOX 40 No		esidence 6 Other (S	Specify)
on	Attending r death. ector: After y the fune	atlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Yea	r) Injury	Work? M 1 ☐ Yes 2 ☐ î	No		
Division	if or Attendated after death Director: A	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A	At home, farm, st	reet, factory, office		(Street and Number or Town, State)	Rural Route Number,
ā	ital or irs afte raf Dir								
	To the Hospital or Attending I within 24 hours after death.  To the Funaral Director: After completely filled in by the funer	Medical				h occurred at the time, date and vestigation, in my opinion, deat			
	To the Comp	Σ	29b. Signature and title of certifier	1 - Ma A	4	29c. License number	$\sim$	29d. Date signed (Mi	onth, Day, Year)
,			force	y al	lu	Dat 3	177	10/17	195
1	8791		30. Name and address of person who c	ompleted cause of death	(Item 23a) (Type,	le Plate	c mo	2066	16
	Sta		31. Date filed (Month, Day, Year)	32. Rajistrar's S	ignature	1.0.			
	Regist	rar	OCT 1 9 2	UUD   Aleeve	J. J.	DEAL)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend State of Maryland / Department of Health and Mental Hygiene 0 5

35286 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** OCTOBER 18, 08:55 A M HELEN CLAIRE CREGAR FLEETWOOD 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CHESTER RIVER HOSPITAL CENTER CHESTERTOWN KENT If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Amonths Days Hours Min. | APRIL 5, 1922 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F NJ 83 Vrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral', or Itams 23e or 28a-f show 1 ☐ Yes 2 No QUEEN ANNE'S CHESTERTOWN MD Director the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21620 USA 211 FEY ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced "netural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 7 Is marked othar than "netul traumatic evant, the Medical 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental h ELSIE EARLE HAGAMAN CHARLES EDGAR CREGAR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 211 FEY ROAD, CHESTERTOWN, MD 21620 RICHARD FLEETWOOD/SON of Health item 27 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages i Department of F Importent: If its any injury or ot once. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State CHESAPEAKE CREMATION OCT. 19, 2005 STEVENSVILLE, MD ` 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 130 SPEER ROAD, CHESTERTOWN, MD 21620 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician VENTRICHLAR TACHYCARDIA seconds /Medical Examiner ATHEROSCLENOTIC CARDIOVASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown WIN HODGKINS LYMPHMA Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No HEART 24a. Was an LONGESTIVE DEMENTIA 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 🗍 Suicide determined 4 T Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2005 00041587 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) NOBLE CHESTERTOWN MD 21620 122 SPEER RD ar's Signature 31. Date filed (Month, Day, Year) 32. Red State OCT 2 0 2005 Registrar

			For State Registrar	-	epartment of Health and Certificate of Death	d Mental Hygien	1070 00701
			Decedent's Name (First, Middle, L.	ast)		2. Date of Death	3. Time of Death
	Physici /Medic		Hazel Fran	ces Gatchell		October :	$17,2005 \mid 11:15A^{M}$
	Examin	er	4a. Facility Name (If not institution, gi Genesis Elder		4b. City, Town, or Location of De	ath 4	c. County of Death
			5 Social Security Number 6	Sex 7 Age (In vrs last hirti	La Plata	Irs. 8. Date of Birth (Month, Day, Yea.	Charles  9. Birthplace (State or Foreign Country)
	Funeral Director		004-03-2045	. T		in. (Month, Day, Yea. August 19,	1911 Maine
	pu *		Usual Residence of Decedent  10a, State 10b, County	10c. City, Town		,	10d. Inside City Limits
	Maryla f sho	or	MD Char		Plata		1 ☐ Yes 2 No
	r 28a-	rect	10e. Street and Number		10f. Zip Code	10g. C	Citizen of What Country?
	th with	ai D	7110 Hawthorn	ne Road	20646		USA
	er dea	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	irs afte	by F	1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 XNo Specify:		Specify: white
215-0036	72 hours after death with the Maryland natural', or ttems 23a or 28a-f show diest Examinatinatibe matter	Completed	15. Decedent's E (Specify only highest g.		Decedent's Usual Occupation (Give kind of work done during most of t	yorking 16b.	Kind of Business/Industry
21	within 7 iene. than "r	mpie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)		
CA	filed v Hygie other t		17. Father's Name (First, Middle, Las		ales Clerk	lame (First, Middle, Maide	rocery Store
lan	ould be filed with Mental Hygiene. arked other than atic event, trail	To Be	Percy Tourte		Effi	e Izora	Gray
Maryland	and and sum		19a. Informant's Name/Relationship		Mailing Address (Street and Number or		
	1 and 2 Health am 27 thar tra		Sharon Glisson		110 Hawthorne Ro		ata, MD 20646  Location - City or Town, State
Baltimore,	Pages 1 nent of H int: if ita iry or ot		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3	Removal from State cemeter	v, crematory or other place)		
Ē			'4 Donation 5 Other (Spec 21. Signature of Funeral Service Lice		Joseph's Cem. 10		
Ba	permit. Departr Imports any Inji		Marid C. E.	chil	<sup>22</sup> AREHARTS ECHOL P.O. BOX 567,	S FUNERAL IA PLATA	HOME, P.A. MD 20646
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that caused the death. Do not your cause on each line.	ot enter the mode of dying, such as card	liac or respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)		ONIA		1-24CS
	/Medical Examiner		1	Due to (or as a consequence of	f):		
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60,	be execian a	EX	resulting in death) Last	Due to (or as a consequence of	rf):		
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-	death he atte	Physician/M	in the past 12 months?	4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
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ita	ertifica ctor, p	BeC	25. Was case referred to medical examiner?			Death (Check only one)	
of V	hysic this ce al dire	2	1 ☐ Yes 2 ☐ XNo	Hospital: 1 Inpatient 2 ER/Out		g Home 5 Residence	
on	ding h. After funer	tion	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigati		ime of piury at work?  M 28c. Injury at Work?  1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred
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	rs after all Dir		4 - Tromicios	building, etc. (Specify)		Only of Formi, Sta	
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medicai	29a. Certifier 1 Certifying F (Check only 2 Medical Ex-	Physician: To the best of my knowledge aminer: On the basis of examination and	, death occurred at the time, date and pla Vor investigation, in my opinion, death o	ace, and due to the cause( ccurred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
	o the o the omple	Mec	29b. Signature and title of certifier	and manner stated.	29c. License number	29d. D	Pate signed (Month, Day, Year)
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1	353		ASHVINKU 31. Date filed (Month, Day, Year)	MAK J BATE  32. Reistrar's Signature	<b>A</b>	Mellon CT	WALDORF
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			For State	State of Maryland	Department of Health and I  Certificate of Death	Mental Hyglen 1 Reg. N	F000 00F00
			Registrar  1. Decedent's Name (First, Middle, Las	1)	i i	2. Date of Death	ay Year 2 2 2 2
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ć	Examin	er	4a. Facility Name (If not institution, give	Merlical Conta	4b, City, Town, or Location of Death		c. County of Death
F	uneral		5. Social Security Number 6. Se		birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Dey, Year	Birtholace /State or Foreign
Di	irector		Usual Residence of Decedent	AM ST.	Yrs. 3c	actober 1	, 2005 Maryland
ryland	how I		10a. State 10b. County	10c. City, T	own or Location		10d. Inside City Limits 11∕2 Yes 2 □ No
ће Ма	or 28a-f show re notified at	Director	Many and Hone	Houndel A	hnapo IS	10g. C	Citizen of What Country?
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r death	er mu	Inera	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
I KIKI 13-0000 filed within 72 hours after death with the Maryland Hyolene.	"natural", or Itams 23a Ideal Exeminer must b	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∰Yes 2 <b>∑</b> Mo If Yes, Give Year or Dates:	1 Yes 2 No Specify:	(ICA)	Specify: HS AMIC
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2 should be filed with	marked other than	2	Lucas Omo	on Escoba	19b. Mailing Address (Street and Number or All	A JERON	ica Gonzalez
			19a. Informant's Name/Relationship (19a. AMELIA ESCOBAR	(MOTHER)	13 Lore that he	tuna anli	s Ud 2 1401
es 1 and of Health	Important: If item 27 any injury or other tr once.		20a. Method of Disposition  1 Burial 2 Cremation 3	20b, Plac	e of Disposition (Name of	h a 06	Location - City or Town, State
t. Pages	ortant: injury o		* 4 □Donation 5 □ Other (Specification of Superior Company Co	" Park	12003		apolis, MD.
permit.	Impol any ir		Xamash	RALLE	600 Kennedy Street		neral Services, INC ington, DC. 20011
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	ding ph		IF FEMALE:	23c. If yes, outcome of pregnance	v		23d. Date of delivery
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Ords, P.O	signed d be de	by	Part II. Other significant conditions of	ontributing to death but not resulti	ng in the underlying cause given in Part I.		b use contribute to the cause of death?  2 No 3 Probably 4 Unknown
MECOTOS, he law requires	s been	ompieted				24a. Was an	24b. Were autopsy findings available
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Of VITAL Physician: T	is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital: V	Other	ath (Check only one)	
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DIVISION C	Director:	Certification;	3 Suicide 6 Could not b 4 Homicide determined		e, farm, street, factory, office	28f. Location (Street: City or Town, Sta	and Number or Rural Route Number, ate)
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To the	romplel	Medical	29b. Signature and title of certifier	and manner stated.	29c. License number	29d. C	Date signed (Month, Day, Year)
^			Varev C.	portant au	D 3232	5 al	DER 1,2005
12	(2)		30. Name and address of person who	completed cause of death (Item 2	3a) (Type, Print) 2001 Wedica O PKI.	1 Annon	li Md 21401
	Sta	ate	31. Date filed (Month, Day, Year)  OCT 1 8 200	. Registrar's Signatul	6		

State of Maryland / Department of Health and Mental Hygiene 05 State
Registrar Amend #5.Per Informent PCC 10-26-0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year GREEN October 17 2005 4:47A<sup>M</sup> ERMA PINKNEY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL Prince Clinton George SOUTHERN MARYLAND If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. iast birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2 F 79 Director 19 1926 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Maryland Prince George Clinton Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8501 Rockwell Drive 20735 23a U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 📉 No þ Specify. 3 Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry School Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Is marked other than P.G. County Public Teacher plus 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Hawkins Cora Sidney Isaiah Pinkney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 of Department of Health ar Important: If Item 27 is any Injury or other trau once. 20735 9508 Oakleaf Place, Clinton, Maryland Anne P. Prince/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham Veteran 10/21/05 Cheltenham, Md. 22. Name and Address of Facility HALL BROTHERS FUNERAL HOME 21. Signature of Furnital Service Florida Avenue, NW, Washington D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Un How /Medical Due to (or as a consequence of): Examiner Ce quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔯 No Month Day 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Division of Vital Records, P. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Durence 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has birector, page 2 s 2 100 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Linpatient 2 ER/Outpatient 3□ DOA Sign Sign After thi 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation Injury death. 1 Tes 2 No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide ertitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signatur and title of ce 29c. License number who co ted cause of death (Item 23a),(Type, Print) 10 9/460 tovingston Rd 3-350 31. Date filed (Month, State Registrar 2005

		•	For State Registrar	State of Marylar	Cei	rtificate of I	Death		2005	35290
Ph	ysicia	n	Decedent's Name (First, Middle, La:  EXPELIZATION	_		an arm		2. Date of Dea Month	Day Yea	
· · · · · //	Medica	al .	EVELYN  4a. Facility Name (If not institution, giv.)	L e street and number)		GREEN 4b. City, Town, or	Location of Death	October	4c. County of D	
	amme	A	Northampton Manor		er	Frede	rick		Freder	ick
Fun Dire	eral ctor		216-14-6350	ex 7. Age (In yrs. □ M 2፟፟፟X F 90		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day OCT . 10	v. Year)	Birthplace (State or Foreign Country) aryland
land	12	-	Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
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vith the	Da us	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	_
leath v	TURBIT	Funeral	2 Kenneth I	Drive 12. Was Decedent Ever in U	J.S. 13.	21793 Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Si	pecify Yes or No-		States merican Indian,
of K. I. 2-0000 tiled within 72 hours after death with the Maryland Hygiene. tither than "naturel", or Itema 23a or 28a-f show	9	2	1 Never Married 2 Married 3 Widowed 4 MDivorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 🗓 No	n, Mexican, Puerti Specify:	o Rican, etc.)	Black, W	Mhite, etc. White
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12 sho h and 7 is m	traum		19a Informant's Name/Relationship ( Betty J. Main	<sub>Турө, Print)</sub> / Daughter					r, City or Town, State , Maryland	
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Pages nent of	iry or		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif					21,2005	Frederick	,Maryland
permit. Pages 1 an Department of Heal Important: if Item 2	any Int.		21. Signature of Funeral Service Licer		) 22	2. Name and Addres	ss of Facility S1	tauffer l		omes, P.A.
				plications that caused the dea one cause on each line.	th. Do not ent	ter the mode of dyin	g, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death
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p <sub>0</sub>	sit	luer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):		· · · · · · · · · · · · · · · · · · ·	-		
icate be executed physicien and	al-tran	Examiner	that initiated events resulting in death) Last	cDue to (or as a consec	quence of):					
te be a	e prici	dical	(	d						
ertificat ling phy	e as th		IF FEMALE:	00-14						
e death c	should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of c 9 Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
that the	detac		Part II. Other significant conditions of	contributing to death but not res	sulting in the u	Inderlying cause give	en in Part I.	23e. Did to	bacco use contribute	e to the cause of death?
quires an sign	should be	ed by	CHRONIC LY	MPHOCYTIC	LEUK	amin		1 🗆 Y	es 2□No 3□	Probably 4 Munknown
ne law re s has bec	ge 2 sho	Completed						24a. Was a autops perfor	sy prior med? death	
an: T	funeral director, page 2	a l	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes ath (Check only or		′es 2□ No
hysic his ce	l direc	LOB	examiner? 1 Yes 2 No		ER/Outpatier		4/25 Nursing H		ence 6 Other (S	pecify)
P P F	(2)	•••	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injun Worl		28d. Describe h	ow injury occurred	
5 = 8 2	funer	5	1 Natural 5 Pending		, mjury	M   1□				
for Attendin after death.	In by the funer	ertification	1 Autural 5 Pending investigation 3 Suicide 6 Could not be determined	9 29a Blace of Joine, At h	nome, farm, str		Yes 2□No	28f. Location (S. City or Town	treet and Number or n, State)	Rural Route Number,
Hospital or Attending 124 hours after death.	letely filled in by the funer	dical Certification:	2 Accident 3 Suicide 4 Homicide Could not be determined	n 28e. Place of Injury - At h	nome, farm, str	reet, factory, office	ne, date and place	City or Town	n, State) ause(s) and manner	as stated.
Atten ar deat	completely fitled in by the funer	Medical Certification	2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only)  2 Medical Exar	28e. Place of Injury - At h building, etc. (Speciarysician: To the best of my kninner: On the basis of examina	nome, farm, str	reet, factory, office	ne, date and place pinion, death occu	City or Town	n, State) ause(s) and manner	as stated. due to the cause(s)
To the Hospital or Attendin within 24 hours after death. To the Funerel Director: Af	completely filled in by the funer		2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	28e. Place of Injury - At h building, etc. (Speciarysician: To the best of my kninner: On the basis of examinand manner stated.	lome, farm, str fy) owledge, deat ation and/or in	h occurred at the time vestigation, in my o	ne, date and place pinion, death occu	City or Town	n, State) ause(s) and manner late and place, and c	as stated, due to the cause(s) onth, Day, Year)
To the Hospital or Attendin within 24 hours after death.	completely filled in by the funer		2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  investigatio 6 Could not b determined	28e. Place of Injury - At h building, etc. (Special sysician: To the best of my kniner: On the basis of examin: and manner stated.	owne, farm, sta fy) owledge, deat ation and/or in	h occurred at the time vestigation, in my o	ne, date and place pinion, death occu e number	city or Town	ause(s) and manner late and place, and of 29d. Date signed (Mo	as stated, due to the cause(s) onth, Day, Year)

	-65	1 - For Amend item 40 Registrar		Cer	tificate of	Death				35291
Physic	an	Decedent's Name (First, Middle, Last,	)				2. Date of De Month	ath Day	Year	3. Time of Death
/Medi Examir	cal	Nicholas Ward Gu 4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Dea	Octobe		2005 nty of Death	13:10
		State Line Motel			Hagers			Wa	shingt	on
Funeral Director		5. Social Security Number 6. Se X 212-70-9406	]M 2□F	s. last birthday) 46 Yrs.	Months Days	If Under 24 Hr Hours Mir		y, Year)		olace (State or Fore ntry) ington, D
P		Usuel Residence of Decedent  10a. State 10b. County	100.0	City, Town or Lo	cation					0d. Inside City Lim
death with the Maryland ms 23a or 28a-f show must be notified at	ā	,		••					1	1 X Yes 2 □
the N	Director	Maryland Worcester  10e. Street and Number	0ce	ean City	10f. Zip Code	· · · · · ·		10g. Citizen o	f What Cour	
With Ba or	ā	14-38th Street Uni	+ 201		21842			JSA	· · · · · · · · · · · · · · · · · · ·	, .
death ms 2:	Funeral	11. Marital Status	12. Was Decedent Ever in		Vas Decedent of I	Hispanic Origin? (	Specify Yes or No	- 14. R	ace - Americ	
or ite	þ	1 Never Married 2 Married 3 Widowed 4 X Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		Yes, specify Cub		irto Rican, etc.)	Spec	lack, White, cify: Whit	
g 2 a	ted	15. Decedent's Edu	cation	16a. Deced	ent's Usual Occu	pation		16b. Kind of		
within 7 ene. then "n	Completed	(Specify only highest grade   Elementary/Secondary (0-12)   12	completed) College (1-4or 5+)	Contra	kind of work done	during most of w d)	onking	Cable	Commo	
Hygir Hygir ther ont,		17. Father's Name (First, Middle, Last)		Concra	ictor	18. Mother's Na	ame (First, Middle	Cable Maiden Sumi		ıy
d be ental ked c	To Be	Richard Lee Guthri	e, Sr.			Marian 1	Edna Weav	<i>i</i> er		
should Mark	F	19a. Informant's Name/Relationship (T)	<del>-</del>	19b. Mailin	g Address (Street	and Number or F	Rural Route Numb	er, City or Tow	m, State, Zip	Code)
nd 2 aith a 27 is		Donna M. Snyder/si	ster	10730	Gambril:	L Park Re	d. Freder	cick, M	D 2170	)2
permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne ent injury or other traumatic event, the Medity ODE.		20a. Method of Disposition  1 Burial 2 XCremation 3 F  4 Donation 5 Other (Specify)	Removal from State		sition (Name of natory or other pla e1 Cremat		tober 14, 2005	20c. Location		
permit. P Departme Importan eny injur		21. Signature of Funeral Service Licens	9 4	GC GC	Name and Addre	ess of Facility Cremat:	ion Servi	ice P.	0. Box	c 784
/Medical Examiner bhysicien and the burial-transit	dical Examiner	resulting in death)  Sequentially list conditions, the leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.	Quence off:						
	Medi	45 CENTAL S								
The law requires that the death certific te has been signed by the atlending to age 2 should be detached for use as	by Physician/Me	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	taf death 3	Ectopic pregnand Other (specify)	у			Date of delive Month	ory Day Year
es that igned b	y P	Part II. Other significant conditions co	ntributing to death but not re	sulting in the ur	nderlying cause gr	ven in Part I.	23e. Did t	obacco use co	ntribute to th	e cause of death?
an sig			····				10	Yes 2□No	3 🗌 Prob	abfy 4 Dunkno
The law requisate has been page 2 should	Completed							osy ormed?	prior to con death?	psy findings availa npletion of cause
	0	25. Was case referred to medical				26. Place of De	1 XYes eath Check only o		1. Yes	ZLI NO
ysicie ils cert direct	To B	examiner? 1 X Yes 2 □ No	Hospitaf: 1 ☐ Inpatient 2 [	☐ ER/Outpatien	t 3 DOA Ot		Home 5 ☐ Resi		ther (Specif	SCENE
Attending Physician: r death. sctor: After this certifica by the funeral director, is	tlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury Found. Day Year) 10-12-05	Found 1:10	28c. fnju Wo		28d. Describe			
if or Attendiater death. Director: A	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Pface of Injury - At building, etc. (Spec	home, farm, str			28f. Location (: City or To: Hagerst	Street and Nun vn, State) St.	nber or Rura ate Li	ne Motel
To the Hospital or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Medical C	29a. Certifier (Check only one)  1 Certifying Phy 2X Medical Exami	Scene sician: To the best of my kn ner: On the basis of examin and manner stated.	nowledge, death nation and/or inv	occurred at the ti restigation, in my	me, date and place opinion, death occ	e, and due to the	cause(s) and r	nanner as si	ated. the cause(s)
the the	Me	29b. Signature and title of certifier			29c. Licen	se number ME		29d. Date sign October		
with Con		The second								
To To con		30. Name and address of person who co		эт 23а) (Турө,	Print) 111 P	enn Stre	et Balt:	imore,	Maryla	and 21201
	ate		ompleted cause of death (fte 30 / TD 32. Regularar's Sign 2005	nature		enn Stre	et Balt:	imore,	Maryla	and 21201

			1 - For Stata Registrar	State of Maryla		irtment of F tificate of		d Mental Hy	giene	05 3	35292
	Physici /Medi Examir	cal	Decedent's Name (First, Middle, Last     A Facility Name (If not institution, give	GRAN	17	4b. City, Town, o	r Location of D	2. Date of Do Month	pay / Day	punty of Death	3. Time of Death
	Funeral Director		222 22 3310	## 2□ F 67	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bi Min. (Month, Di 12/31/]	rth ay, Year) L937	Count	ace (State or Foreign try) Island
	Maryland	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Wicomic		ity, Town or Lo					10	0d. Inside City Limits 1 ☐ Yes 2X No
	ath with the 23a or 28	rai Director	10e. Street and Number 1005 Hinman lane			10f. Zip Code 2180	4		-	of What Count SA	try?
9000	be filed within 72 hours after death with the Maryland ital Hyglene. d other then "natural", or Items 23a or 28a-f show event, tre Medical Exertine must be rotilized at	d by Funeral	11. Marital Status 1 □ Never Married 2 💆 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in I Armed Forces? 1 X Yes 2 □ No If Yes, Give Nav Year or Dates:	f	Vas Decedent of H Yes, specify Cuba	lispanic Origin an, Mexican, P Specify:	? (Specify Yes or No uerto Rican, etc.)		Race - America Black, White, e pecify: whi	etc.
21215-0036	filed within 72 t Hygiene. Ither then "natuent, I'ra heale	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12	cation e <i>completed)</i> Coflege (1-4or 5+)	(Give	ent's Usual Docup kind of work done 20 NOT use retired	during most of	working		of Business/Ind	
Maryland		To Be	17. Father's Name (First, Middle, Last)  John C. Grant				Flor	Name (First, Middle Cence Shee	han	,	
	t and 2 steads are trausing tr		19a. Informant's Name/Relationship (T) Maureen R. Grant/1  20a. Method of Disposition	wife		Hinman		Rural Route Numb Salisbury,	MD 2		
Baltimore,	Pages nent of ont: If it		1 ■ Surial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licent	Removal from State	cemetery, crem rsons C	enetery	10	)/21/05	Salis	sbury, I	MID
Ba	permit. Departn Importe any inju		23a. Part1. Enter the disease, or compl	treray (FS	50	Ol Snow H	Hill Rd	Home Pro	ury, M	ID 21804	sociation L Approximate
-5	Physician /Medical Examiner		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.  MALIGN  Due to (or as a conse	VANT	PANO	REA	Tic o		-	Interval Between Onset and Death
8760,	death certificate be executed e attending physicien and of or use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.  Due to (or as a consect.	quence of):	TNCB,	R.				
.O. Box 6	death certifii e attending p d for use as	Physician/Med	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet: 4 ☐ Pregnant at time of 6	al death 3 🗌	Ectopic pregnancy Other (specify)			23d	Date of deliver	y Day Year
Ω.	v requires that the been signed by th should be detache	þ	Part II. Other significant conditions con	ntributing to death but not re	sulting in the un	derlying cause givi	en in Part I.		obacco use o		e cause of death?
Vital Records,	The law ate has b page 2 st	e Completed	OF Was area referred to region					1 ☐ Yes	osy ormed? 2 No	prior to com death?	sy findings available pletion of cause of
ŏ	ding Phys h. After this funeral din	ToB	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	lospital: 1 Inpatient 2 Inpatient 2 Robert 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun World	er: 4 🗆 Nursin	Death Check only of g Home 5 Resident R	dence 6		HOSPICA
Divis	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	i Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	fy) 			City or Tou	vn, State)	umber or Rural	
	To the Hos within 24 hc	Medical	one)	sician: To the best of my kni ner: On the basis of examina and manner stated.	ation and/or inv	estigation, in my of	pinion, death o	ccurred at the time,	date and pla	ce, and due to t	the cause(s)
)	0 MP 1.	_	29b. Signature and title of certifier  30. Name and address of person who co		m		5 84	10	10	gned (Month, D	5
	Sta Registr	- 10	31. Date filed (Month, Day, Year) 20	RIS 26.2 6	G A Pature	LROW W	00000	T. SA	LISBU	NRY "	10812 an

Cornelius G-reen 7 219-98.32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear **Physician** Cornelius DeWitt Green 1243 Ortober 13, 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomies SA/15649 FENINSULA RECEINA 8. Date of Birth (Month, Day, Year) Tune 16, 1976 Year If Under 2 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Age (In vrs. last birthday) 6. Sex **Funeral** Hours Days 1 □XM 2 □ F Salisbury, 29 Yrs. 212-98-3342 Director Usual Residence of Decedent death with the Maryland 10b County 10c. City, Town or Location 10d. Inside City Limits 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at 1XYes 2 □ No Salisbury Completed by Funeral Director Wicomico MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S. 21822 4150 Allen Rd. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 █XNo Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 should be filed within and Mental Hygiene.
Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Home Improvement Carpenter 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be Cynthia Emory Thomas Joseph Green ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If itam 27 Is any injury or other trai once. 4150 Allen Rd., Eden, MD 21822 Cynthia L. Green/ Mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Green Acres Memorial Park Salisbury, MD 10/22/05 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MALIGNANT INTRACRANIAL HYPERTONSION disease or condition resulting in death) /Medical Examiner LEFT TOMPURAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit certificate be executed Due to (or as a consequence of): physician Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Wunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient ပ 2 ER/Outpatient 3 DOA 1 Yes Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1XNatural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month. Dav. Year) 29c. License number 29b. Signature And title of certifier OCTUBER 13 2505 on who completed cause of death (Item 23a) (Type, Print) SALISBURY MO 18RRE DOE. CARROLL

DHMH 17 Rev 1/2001

State

Registrar

32. Registrar's Signature

th, Day, Year)

1 9 2005

31. Date filed (Month.

State of Maryland / Department of Health and Mental Hygiene 0 05 For State Registrar Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) October 16,2005 11:30aM Physician Virginia Adams Heffernan /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Montgomery Casey House Rockville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Aug 12,1931 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 € F Rochester, NY 74 095-24-2967 Director Usual Residence of Decedent 10d. Inside City Limits death with the Manyland 10c. City, Town or Location 10a. State 10b. County r then "naturel", or iteme 23a or 28e-f ehow the Medical Examinar must be notified at 1 ☑ Yes 2 ☐ No Bethesda Director MD Montgomery 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number United States 20816 5216 Falmouth Rd Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No 11. Marital Status e filed within 72 hours after II Hygiene. other then "naturel", or Ite 1 Never Married 2 Married <sub>Specify</sub>White 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify f Yes, Give þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Family Life Specialist Sociology permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Important: If Item 27 Is marked other the eny injury of other treumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Olsen Harry Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5216 Falmouth Rd, Bethesda, Md 20816 James Heffernan / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 10-19-05 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Gate Of Heaven Cem 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons, INC her 5130 Wisconsin Ave, N.W. Washington DC 20016 de 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician End Stage Renal Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physicien IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day 0 in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 page 2 should be 3 Probably 4 Unknown 1 ☐ Yes 2X No Diabetes Mellitus Type II Completed 24b. Were autopsy findings available pnor to completion of cause of death? has autopsy performed? 2 □ No certificate 1 Yes 2 No 1 ☐ Yes Attending Physicien: After this certification funeral director, I 26. Place of Death Check only one 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 → No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Japital ...
A hours efter dea...
Aret Director: After 5 Pending 1 TYes 2 No investigation 2 Accident To the . within 24 hours . To the Funerel Directur. 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Rd, Rockville, MD 20853 Charles Harrison M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 18 2005

		For State Registrar	State of I		d / Depa		of H	ealth a		•		_	35295
Physicia /Medic		1. Decedent's Name (First, Middle, Last	ODGE							2. Date of De	ath	2005 <sup>Year</sup>	3. Time of Death 10:50 ам
Examin	- 1	4a. Facility Name (If not institution, give 512 Spring Glad	le Rd.				ak1a	nd			Ga	County of Dearrett	
Funeral Director		5. Social Security Number 6. Se 197 34 5464	7. ]M 2 <b>∐</b> F	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da FeD.	7 <sup>4</sup> 194	9. Bi	rthplace (State or Foreign ennsylvania
Maryland -I show	tor	10a. State 10b. County MD Garrett	:	10c. City	, Town or Lo Oak1								10d. Inside City Limits 1 ☐ Yes 2 ☐ No
with the 3a or 28e	Funeral Director	10e. Street and Number 512 Spring Glade	e Rd.			10f. Zip (	550				10g. Citize	en of What C	Country?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Department of Health and Mental Hydiene. The proportants if item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other treumatic event, I'm Madical Evantiner must be nutified at once.	by	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	ss? █ No		Vas Decede Yes, speci		spanic Ori , Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		4. Race - Am Black, Wh Specify: W	
within 72 houpine.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12	cation e completed) College (1-4 4	or 5+)		lent's Usual kind of work OO NOT use .erk	Occupa done di retired)	tion uring mos	t of worki	ing		d of Busines nking	s/industry
uld be filed Mental Hyg arked otheratic event,	To Be C	17. Father's Name (First, Middle, Last) Harold R. Hoo	lge,Sr.							a (First, Middle, a Herri		Surname)	
C, Mal) Tand 2 sho Health and I Sm 27 Is ma	·	19a. Informant's Name/Relationship (T)  Brenda Kakick  20a. Method of Disposition	vpe, Print)	20b. P	5	12 Sp	ring	G1a	de R	d. Oak	land,	, MD	Zip Code) 21550 r Town, State
it. Pages utment of the ortant: If ite		1 ☐ Burial 2 ☑ Cremation 3 ☐ f  '4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of funeral Service Licens		cate Cu	lace of Dispo emetery, crem mber1a	nd Cr . Name and	emat	ory	10/2	6/05	Cumh	oerlan	
permi Depa Impo eny k		23a Part 1 Enter the disease or comp	Dunclo	R sed the death		21 N.	_2nc	St.	0a	rdock/D kland, or respiratory as	MD 2	21550	Approximate
Physician /Medical Examiner		shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a		CVD uence of):								Interval Between Onset and Death years
te be executed ysician and te burial-transit	licai Examiner	resulting in death) Last	c.	as a consequ									
To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely tilled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months2 1 □ Yes 2 □ NO 9 □ Unknown		n 2 ☐ Fetal It at time of de	death 3	Ectopic pre Other (spe					23	3d. Date of de Month	blivery Day Year
requires that requires that een signed b	by	Part II. Other significant conditions co	ntributing to deal	th but not resu	ulting in the ur	nderlying ca	use give	n in Part I.		23e. Did t			to the cause of death?  Probably 4 Unknown
VICAL DECO sician: The law re- s certificate has bee lirector, page 2 sho	Completed									24a. Was autor perfo	rmed?	prior to death?	autopsy findings available completion of cause of s
To the Hospitel or Attending Physicien: The Within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	To Be	27. Manner of Death Natural 5 Pending	Hospital: 1 ☐ Inp 28a. Date of (Month,		ER/Outpatien 28b. Time of Injury		la. Injury Work	r. 4□Nu	rsing Ho	me 5 Residence 28d. Describe	dence 6		ecify)
To the Hospitel or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building	Injury - At ho , etc. (Specif)	ome, farm, str				-	28f. Location (3 City or Tox		Number or F	Rural Route Number,
ne Hospite n 24 hours he Funeral pietely fiile	edicai C	29a. Certifier (Check only one)  Certifying Phy Description  Certifying Phy Descriptio	sician: To the biner: On the bas	is of examinat	wiedge, death tion and/or inv	occurred a restigation,	t the tim in my op	e, date an inion, dea	d place, th occurr	and due to the ed at the time,	cause(s) a date and p	and manner a place, and du	is stated. le to the cause(s)
Tot withi Tot com	Z	29b. Signature and title of certifier	~			290	License	23	33		29d. Date	signed (Mor	ith, Day, Year)
5		30. Name and address of person who control of the state o	nson 3	311 N.	4th S		akl.	and,	MD	21550			
Sta Registi		31. Date filed (Month, Day, Year) OCT 2 6 20	100	jistrar's Signa		and I							

of Maryland / Department of Health and Mental	Hygie Re 15	3	5	2	9	- Contract
0 - 4151 - 4 5 10 46	Em O O		-	E-400	_	
Certificate of Death	Reg. No.					

**Physician** /Medical Examiner

**Funeral** Director

filed within 72 hours after death with the Maryland in then "naturel", or items 23a or 28e-1 show the Medical Examiner must be notified at Hygiene. lith and Mental Hygis 27 is marked other r treumatic event, other Pages 1 and 2 should ba if item 27

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

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parmit. Page Department o Importent: If any injury or

The law requires that the death certificate be executed burial-transil the as esn bed f the signed by the page 2 or Attending Physician: director, this completely filled in by the funeral After death. after death Director:

Division of Vital Records, P.O. Box 68760,

2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death October 16, 2005 Robert Humphries 7:30A M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Charlotte Hall Veterans Home Charlotte Hall St. Mary's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Carolina 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1**∑**M 2□ F Days Hours 412-28-6971 82 Yrs. Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits St. Mary's Maryland Charlotte Hall 1 Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 29449 Charlotte Hall Rd. 20622 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Aes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Specify Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Labor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Robert Humphries Julie Ross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4675 Spencer Pl., Nanjemoy, MD 20662 Annie Brevard/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery Oct. 21, 2005 Cheltenham, MD A □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 21. Signature of Funeral Service Licensee 30195 Three Notch Rd., Charlotte Hall, MD 20622 عريا 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to firm sollate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year Month 5 Other (specify) 4☐Pregnant at time of death ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Pobably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 Yes 1 TYes 2 🗆 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ce tifier D0061947

8 541 State

To the Hospitai within 24 hours a

DHMH 17 Rev 1/2001

Registrar

29449 Charlotte Hall Road Charlotte Hall, Md. 20622

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Raistrar's Signature

Manoj Mathur, M.D.

OCT 1 9 2005

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiepe 05 35297 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Nancy Roberta Brew Hall 13:58 PM 13,2005 October /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince George Hospital Cheverly Prince George If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 □ M 2 □ F Yrs. Director 579-50-3449 68 Nov 27, 1936 Lynchburg VA Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is markad other than "natural", or Itams 23a or 28a-f show traumatic evant, the Medical Exprehent mater and the natified at Y□Yes 2□No Directo Maryland Prince George Capital Heights 10g. Citizen of What Country? 10f. Zip Code with 1 6320 Martin Luther King Jr Highway 20743 United States e filed within 72 hours after death to all Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry United States Postal Elementary/Secondary (0-12) Twelth College (1-4or 5+) Mail Handler Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth any injury or other traumatic event QNCS. Pat Royal Bessie Brew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Plater/Daughter 9124 Banleigh Lane, Clinto, MD 20735 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ₺ Burial 2 Cremation 3 Removal from State October 13, 2005 Resurrection 4 ☐ Donation 5 ☐ Other (Specify) Clinton Maryland 22. Name and Address of Facility Robert G. Mason Funeral Home 21. Signature of Funeral Service Licensee 1661 Good Hope Rd SE, Wash DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardio Respiratory Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Metabolic Encephalopathy to 5 years Sequentially list conditions, it any, reading to initial date cause. Enter Underlying Cause (Disease or injury Due to for as a nonsequence of Examiner requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit End Stage Renal Disease 4 to 5 years that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical Coronar Arter Disease to 5 years IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 25 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hypertension 1 Yes 2 No 3 Probably 4 Unknown Completed Diabetes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Coronary Artern Bypass Status 2 1 No 1 Yes 2√ No 1 Yes or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: Certification: To 1 ☐ Yes 2 ☑ No Month 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 Tyes 2 No investigation 2 Accident after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 29a. Certifier 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 1)24095 10-14-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pragna Patel M.D. 5632 Annapolis Road #11, Bladensburg, MD 20710 31. Date filed (Month, Day, Year) . Registrar's Signature State OCT 1 8 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 05 1 - For State Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Alfred Strayer Hancock 2005 17, 0213 A. M Oct. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hartley Hall Nursing Home Pocomoke Worcester If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 4-3-1921 5. Social Security Number Funeral 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Md. Yrs. Director 220-01-3283 84 Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Madical Examinar must be notified at Director 1X Yes 2 No Worcester Pocomoke 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1004 Cedar St. 21851 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: 42-45 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any injury or other traumatic event, the Medical Exempt Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No à 3 Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor of Instruction Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alfred C. Hancock Ella S. Johnson Hancock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Hancock, Son 305 Winter Quarters Dr. Pocomoke City, Md. 21851 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Beth Eden Cemetery 10-19-05 Pocomoke City, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Short Funeral Home, Inc. wil 13 E. Grove St. Delmar, De. 19940 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Proysician Hortic evere /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ğ in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death Month Day Year 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed' this certificate 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death Check only one) examiner' Other: 4 Vursing Home 5 Residence 6 Other (Specify) ျှ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of After 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) yothin 2 29b. Signature and title of certifier-29c. License number 29d. Date signed (Month, Day, Year) 54422 10-17-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 604-Market St. to comoke 32. R. sistrar's Signature State OCT 1 8 merki Registrar

			1 - For State Registrar	State of M	aryland / Depa <i>Cei</i>	artment of I <i>tificate of</i>		and Mer	ntal Hygier	CUU	35299
ı	Physic		1. Decedent's Name (First, Middle, Last) Sharlene Dona Hil	1				2.	Date of Death Month	Day Yea	
	/Medic Examir		4a. Facility Name (If not institution, give s	treet and number	VI CONTU	4b. City, Town,	64/156	ury		4c. County of D	eath
	Funeral Director		220-32-2000	M 2/DF	ge (In yrs. last birthday) 70	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, Yea -10-1935	9. I	Birthplace (State or Foreign Country) De •
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside City Limits
	Many B-f sh	ţoţ	De. Sussex		Laurel						1 □ Yes 2X□ No
	or 28	)irec	10e. Street and Number			10f. Zip Code			10g. 0	Citizen of What	Country?
	23a	ral	11809 Hickman Dr.			199	956		Ţ	JSA	
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other than "neturel", or items 23a or 28e-1 show or other treumstic event, the Medical Examinar must be notified at	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  XX Widowed 4 Divorced	<ol> <li>Was Decedent Armed Forces?</li> <li>1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:</li> </ol>	No.	Vas Decedent of I Yes, specify Cub □ Yes 2 No		gin? (Specify , Puerto Rica	Yes or No- an, etc.)	Black, W	merican Indian, hite, etc. Vhite
21215-0036	within 72 ho ene. than "netur he Modical	pleted	15. Decedent's Educ (Specify only highest grade	ation completed) College (1-4or	(Give	lent's Usual Occup kind of work done OO NOT use retire	pation during most d)	of working	16b.	Kind of Busine	ss/Industry
	filed wit Hyglen other tha	Con	12			rator				Phone	Co.
Maryland	ld be fill ental H ked oth ic even	To Be	17. Father's Name (First, Middle, Last)  Cecil Wright						irst, Middle, Maide Lett Wrig		
lary	2 should and Men is marke eumatic	-	19a. Informant's Name/Relationship (Typ	*			and Number	r or Rural Ro	oute Number, City	or Town, State	o, Zip Code)
	1 and Health sm 27 ther tr		Wayne A. Hill, Son 20a. Method of Disposition		20b. Place of Dispos	3 Hickma	in Dr.	Laur	el, De.		
Baltimore,	Pages nent of I ont: If its		1  Burial 2  Cremation 3  Re 1  Donation 5  Other (Specify)	moval from State		atory or other pla	· 1	0-24-0	1, 200	Location - City :	
Balti	permit, Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre <u>900.9.</u>		21. Signature of Funeral Service License	•		Name and Addre					
			23a. Part1. Ever the disease, or compleshock, or head failure. List only of	ations that caused cause on each li	d the death. Do not ente	er the mode of dying	ng, such as o	cardiac or re	spiratory arrest,	. 7740	Approximate Interval Between Onset and Death
	Prrysician /Medical	H	Immediate Cause (Final disease or condition resulting in death)		ricular	tachy o	ysryl	hm19.	5		Onset and Death
	Examiner			Due to (or as	a consequence of):	8 . 1	. ,				
	D =	iner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):	-					
	xecute and Il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):						
8760,	icate be executed physician and s the burial-transit	dical E	d								
Box 68	death certifica attending ph d for use as th	0	230. Was decedent pregnant	c. If yes, outcome 1⊟Live birth		Ectopic pregnanc	ď			23d. Date of d	,
P.O. E	that the death cer ed by the attendin detached for use	Physiclan/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐ Unknown		Other (specify)				Month	Day Year
	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit		Part II. Other significant conditions conf	ributing to death b	out not resulting in the un	derlying cause giv	ren in Part I.		23e. Did tobacco		to the cause of death?  Probably 4 🛣 Unknown
Vital Records,		Completed by							24a. Was an autopsy performed?	prior to death?	autopsy findings available completion of cause of 2 No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	espital: 🏒					neck only one)		
of	Phys	- To	1 ☐ Yes 2 No  27. Manner of Death	1 A Inpatie		3☐ DOA Oth 28c. Injur	4 🗌 Nur	-	5 Residence		pecify)
O	Attending I ir death. ector: After by the funer	tlon	1≱Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	y Year) Injury	Wor	k? Yes 2⊟N		Describe now inj	ury occurred	
Division	al or Attendia after death. I Director: Al d in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At home, farm, stre c. (Specify)	et, factory, office		28f.	Location (Street a City or Town, Sta	and Number or i te)	Rural Route Number,
1	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical Ce	29a. Certifier (Check only one) (Check only one)	er: On the basis of	of my knowledge, death f examination and/or inv	occurred at the tirestigation, in my o	ne, date and pinion, death	place, and on occurred a	due to the cause(s	s) and manner and place, and du	as stated. ue to the cause(s)
	o the ithin 2 o the	Med	29b. Signature and title of certifie	and manner sta	ated.						
-	- 3 + β		1 2011	Ru		14603	5936	8	10	115/2	\$
	tof		30. Name a arriss of person who cor	noleted cause of d	leath (Item 23a) (Type, F	Print)	7 Sa	lisher	n MD	2/80<	7 .
	Sta Registr		31. Date filed (Month, Day, Year)  OCT 1 8 20	32. Pagistr	leath (Item 23a) (Type, F 100 C, C ar's Signature	all)			· J		

Marlen Hul 130-33-3066

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## CCT. 16, 2005    Figure   Facility Name   Improve   Impro				1. Decedent's Name (First, Middle, L	ast)		2. Date of Death	3. Time	of Death
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17. Faither's Name (First, Middle, Master Surmana)  18. Mailing Address (Street and Variante or Fluid Pounts Names City or Town, State, 25 October 1998)  19. Mailing Address (Street and Variante or Fluid Pounts Names City or Town, State, 25 October 1998)  19. Mailing Address (Street and Variante or Fluid Pounts Names City or Town, State, 25 October 1998)  19. Mailing Address (Street and Variante or Fluid Pounts Names City or Town, State, 25 October 1998)  19. Mailing Address (Street and Variante or Fluid Pounts Names City or Town, State, 25 October 1998)  19. Mailing Address (Street and Variante or Fluid Pounts Names City or Town, State, 25 October 1998)  19. Mailing Address (Street and Variante or Fluid Pounts Names City or Town, State, 25 October 1998)  19. Mailing Address (Street and Variante or Fluid Pounts Names City or Town, State, 25 October 1998)  19. Mailing Address (Street and Variante or Fluid Pounts Names City or Town, State, 25 October 1998)  19. Mailing Address (Street and Variante or Fluid Pounts Names City or Town, State, 25 October 1998)  19. Mailing Address (Street and Variante or Fluid Pounts Names City or Town, State, 25 October 1998)  19. Mailing Address (Street and Variante or Fluid Pounts Names City or Town, State, 25 October 1998)  19. Mailing Address (Street and Variante or Fluid Pounts Names City or Town, State, 25 October 1998)  19. Mailing Address (Street and Variante or Fluid Pounts Names City or Town, State, 25 October 1998)  19. Mailing Address (Street and Variante or Fluid Pounts Names City or Town, State, 25 October 1998)  19. Mailing Address (Street and Variante or Fluid Pounts Names City or Town, State, 25 October 1998)  19. Mailing Address (Street and Variante or Fluid Pounts Names City or Town, State, 25 October 1998)  19. Mailing Address (Street and Variante or Fluid Pounts Names City or Town, State, 25 October 1998)  19. Mailing Address (Street and Variante or Fluid Pounts Names City or Town, State, 25 October 1998)  19. Mailing Address (Street and Variante or Fluid Pounts	2		5	Ma		01:= 8:10:1		1 <b>∑</b> Ýe	s 2 No
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Physician / Medical Examiner    Physician / Medical Examiner	N	her i	ပိ	17 February Name / First Middle Los					
Physician / Medical Examiner    Physician / Medical Examiner	2	d of	Be	T. Fallier's Name (First, Wildure, Las	7.1	18. Mothers N	iame (First, Middle, Ma	aiden Sumame)	
Physician / Medical Examiner    Physician / Medical Examiner	View S	Merka	ပို				TA PE	ARL NORRIS	
Physician / Medical Examiner    Physician / Medical Examiner	<u>a</u>	and eum		19a. Informant's Name/Relationship	(Type, Print) 19b. M	lailing Address (Street and Number or	Rural Route Number,	City or Town, State, Zip Code)	
Physician / Medical Examiner    Physician / Medical Examiner		n 27		LEETTA P. NORR		BUENA VISTA	HVE~SAL	15 BURY MD. 2180	o i
Physician / Medical Examiner    Physician / Medical Examiner	ore .	roth Tran		· _ ·	comoton	sposition (Name of crematory or other place)	Date 20	Oc. Location City or Town, State	
Physician / Medical Examiner    Physician / Medical Examiner	E Page	int: I			1 1	ottails Pan in	122/25	FOEN MD	
Physician / Medical Examiner    Physician / Medical Examiner	=======================================	oorts inju		21. Signature of Funeral Service Lice			ELMIE S		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final Immediate Cause (	m 8	2 2 2 3		4- Auscilla	Kninds	917 WTERREUMS	-		
Physician / Medical Examiner    Physician / Medical Examiner   Medical		×		23a. Part1. Enter the disease, or cor	nplications that caused the death. Do not	enter the mode of dving, such as card			ate
Medical Examiner   Dies to (or as a consequence of):	18			snock, or neart failure. List onf	y one cause on each line.		, ,	Interval Be Onset and	etween
Due to (or as a consequence of):    Consequence of the consequence of				disease or condition	, u.	and blust piece i	guries		
Due to (or as a consequence of):    Section   Description    F				Due to (or as a consequence of):		9			
Top   Top			-	Sequentially list conditions,	b				
Top   Top	99	÷	ine	cause. Enter Underlying	Due to (or as a consequence or):				
Top   Top	ecut	and -tran	кап	that initiated events	C.				
The control of the co	000	cian		<b>3</b>	Due to (or as a consequence of):				
STATE OF THE STATE	87(ate	- W			d.				
STATE OF THE STATE	<b>6</b>	ng p	Med	IE EEMALE:					
STORY OF TOWN STREET, BALTIMORE, MARYLAND 21201	Õ	endi r use	Jug	23b. Was decedent pregnant		3 Ectonic preenancy		23d. Date of delivery	
25. Was case referred to medical examiner?  10	. ag	e att	ici		4☐Pregnant at time of death			Month Day	Year
25. Was case referred to medical examiner?  10	O. B	by th	hys	9 Unknown	9 Unknown				
25. Was case referred to medical examiner?  10	s tha	ned e del		Part II. Other significant conditions	contributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of	death?
25. Was case referred to medical examiner?  10	rd Spr	pis n d blu	D D				1 ☐ Yes	2 No 3 Probably 4 □	]Unknown
25. Was case referred to medical examiner?  10	0 8	shou	ete				240 1460	045 144	
25. Was case referred to medical examiner?  10	a a	has ge 2	E				autopsy	prior to completion of	cause of
1   Natural   2   Accident   3   Suicide   4   Homicide   4   Ho	- E	cate r, pa							
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1   Natural   2   Accident   3   Suicide   4   Homicide   4   Ho	of skill	this dir			1 Inpatient 2 K ER/Outpa	tient 3 DOA 4 Nursing	Home 5 ☐ Residence	ce 6 □Other (Specify)	
29a. Certifier (Chartest of page 29a)  29a. Certifier (Chartest of page 29a)  29a. Certifier (Chartest of page 29a)  29a. Certifier (Chartest of page 29a)  29a. Certifier (Chartest of page 29a)  29b. Signature and title of certifier  29c. License number  O. C. M. E  29d. Date signed (Month, Day, You of page 29a)  30. Name and address of person who complete Cause of death (Item 23a) (Type, Print)  Tasha Zave where the time, date and place, and due to the cause(s) and manner as stated.  29c. License number  O. C. M. E  OCT. 16, 200  30. Name and address of person who complete Cause of death (Item 23a) (Type, Print)  Tasha Zave where the time, date and place, and due to the cause(s) and manner as stated.  29d. Date signed (Month, Day, You of page 29d. Date signed (Month, Day, You of page 29d. Date signed (Month, Day, You of page 29d. Date signed (Month) Day, Yo	C g	Miter	on:	_	28a. Date of Injury 28b. Time (Month, Day Year) Injur	e of 28c. Injury at Work?	28d. Describe how	0	
29a. Certifier (Chartest of page 29a)  29a. Certifier (Chartest of page 29a)  29a. Certifier (Chartest of page 29a)  29a. Certifier (Chartest of page 29a)  29a. Certifier (Chartest of page 29a)  29b. Signature and title of certifier  29c. License number  O. C. M. E  29d. Date signed (Month, Day, You of page 29a)  30. Name and address of person who complete Cause of death (Item 23a) (Type, Print)  Tasha Zave where the time, date and place, and due to the cause(s) and manner as stated.  29c. License number  O. C. M. E  OCT. 16, 200  30. Name and address of person who complete Cause of death (Item 23a) (Type, Print)  Tasha Zave where the time, date and place, and due to the cause(s) and manner as stated.  29d. Date signed (Month, Day, You of page 29d. Date signed (Month, Day, You of page 29d. Date signed (Month, Day, You of page 29d. Date signed (Month) Day, Yo	Sio	or: A	ati	2 ☐ Accident investigation	on 0+16,2005 3:15	- → M 1 Tes 2 No	( who ye it	allar Hel	
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29a. Certifier  29a. Certifier  29b. Signature and title of certifier  30. Name and address of person who complete scause of death (Item 23a) (Type, Print)  Tasha Zeweenberz 1.0 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29c. License number  O.C.M.E  29d. Date signed (Month, Day, You of the cause)  30. Name and address of person who complete scause of death (Item 23a) (Type, Print)  Tasha Zeweenberz 1.0 111 PENN STREET, BALTIMORE, MARYLAND 21201	تة ص	al Di ed ir	Ö	.,	1000000		E. Church +	15-60110 40	MD
29b. Signature and title of certifier  29c. License number  O.C.M.E  29d. Date signed (Month, Day, Ye  OCT. 16, 200  30. Name and address of person who complete Cause of death (Item 23a) (Type, Print)  Tasha Zaveenbers H.D. 111 PENN STREET, BALTIMORE, MARYLAND 21201	loso	hour uner ly fill		29a. Certifier 1 ☐ Certifying P	hysician: To the best of my knowledge, de	eath occurred at the time, date and place	ce, and due to the cau	se/s) and manner as stated	
30. Name and address of person who complete Cause of death (Item 23a) (Type, Print)  Taska Z Greenberz H. D 111 PENN STREET, BALTIMORE, MARYLAND 21201	¥ e	n 24 ne Fi	edic	O'ISCA SIAY AZ I MEDICAI EXA	miner. On the basis of examination and/or	r investigation, in my opinion, death occ	curred at the time, date	and place, and due to the cause(	s)
30. Name and address of person who complete Cause of death (Item 23a) (Type, Print)  Taska Z Greenberz H. D 111 PENN STREET, BALTIMORE, MARYLAND 21201	To th	To tt	Σ	29b. Signature and title of certifier			29d		
Taska Z Greenberg M.D 111 PENN STREET, BALTIMORE, MARYLAND 21201		0		1.1.DM	e and min	O.C.M.E		OCT. 16, 2005	
Taska Z Greenberg M.D 111 PENN STREET, BALTIMORE, MARYLAND 21201	3	M		30 Name and address of same inter	complete cause of death (line 20a) CT	no Print)			
The state of the s		VIII			111 5-	NN STREET. BALTIM	ORE, MARYLA	ND 21201	
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registral		Sta Registr		OCT 1'8	2005 Maria Is	Sparke			

			1 - For State Registrar		aryland / Dep <i>Ce</i>	artment of H rtificate of I		Re	g. No.	3530I
	Physicia		<ol> <li>Decedent's Name (First, Middle, GEORGE W. IRML)</li> </ol>					2. Date of Death Month OCTOBER	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution,	give street and number)			Location of Death		4c. County of Dea	
	Funeral Director		HERON POINT  5. Social Security Number  096–16–3427	5. Sex 7. Ag 1 ☑ M 2 ☐ F	e (In yrs. last birthday 93 Yrs.		STERTOWN  If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, SEPT. 23,	KENT  9. Bit 1912 NY	thplace (State or Foreign
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Maryl e-f eho	tor	MD KENT	Г	CHESTER					1 ∑Yes 2 □ No
	th with the 23a or 28 rat be not	Funeral Director	10e. Street and Number 468 HERON POINT			10f. Zip Code 216	20		g. Citizen of What C USA	ountry?
020	be filed within 72 hours after death with the Maryland Hygiene. Hygiene and chter then "neturel", or items 23a or 28e-f ehow other then "neturel", or items 23a or 28e-f ehow event, it e Madical Examinar must be notilised at	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? d 1 Tes 2 If If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Sp. un, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	te, etc.
2	n 72 h	Completed	15. Decedent's (Specify only highest	grade completed)	lite	edent's Usual Occup e kind of work done o DO NOT use retired	ation during most of work	ing 1	6b. Kind of Business	/Industry
7 7	e filed within al Hygiene. i other then ' vent, it e Ma	Somp	Elementary/Secondary (0-12)	College (1-4or 5	5+)	PS MASTER	•		SHIPPING	
	be file	Be	17. Father's Name (First, Middle, La HENRY IRMLER	ast)			18. Mother's Name	e (First, Middle, M CHAMBERO		
ar y	s 1 and 2 should be f Heelth and Menta item 27 le marked other traumatic ev	<u>و</u>	19a. Informant's Name/Relationship	p (Type, Print)	19b. Mail	ing Address (Street			City or Town, State,	Zip Code)
ž.	1 and 2 theelth are tem 27 le		KENNETH IRMLE	R / SON					, CT 0690	
Daltimore	Pages 1 ment of H ant: If itel ury or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Special Control	B □Removal from State		matory or other plac	(e)		5 STEVENS	
Dall	permit. Pages Department of Important: If i any injury or once.		21. Signature of Euneral Service Li	Helfert		22. Name and Address FELLOWS, 130 SPEER		N & NEWN	AM FUNERA	L HOME, P.A. 20
	Hiticate be executed  g physician and as the buriat-transit	I Examiner	23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Find in John Cause (Disease or injury that initiated events resulting in death) Last	a	a consequence of):  a consequence of):		i womA		St,	Approximate Interval Between Onset and Death
.O. Box 68/60	sath certif ettending for use a:	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	2 Fetal death 3	□Ectopic pregnancy	,		23d. Date of de Month	olivery Day Year
cords, P	w requires that the de been signed by the should be detached	ρχ	Part II. Other significant condition	s contributing to death b	out not resulting in the	underlying cause giv	en in Part I.	23e. Did tob		o the cause of death?
Lec	The law ate has b page 2 sl	Completed						24a. Was an autopsy perform	ed? death?	utopsy findings available completion of cause of
VII	elcian: certific irector,	o Be (	25. Was case referred to medical examiner?	Hospital:		Oth	05	h (Check only one		
п О	Attending Phyelcian: r death. ector: After this certific by the funeral director.	-	1 Yes 2 No  27. Mar of Death  Natural 5 Pending	28a. Date of Inju (Month, Da	ıry 28b. Time	ent 3 DOA	y at	me 5 Aesider 28d. Describe ho	nce 6 Other (Spewinjury occurred	əcify)
DIVISION	in Direction	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place of Inj	jury - At home, farm, s c. (Specify)		Yes 2 □ No	28f. Location (Str. City or Town,	eet and Number or F State)	tural Route Number,
-	Hospite 24 hours Funerel stely filled	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best xaminer: On the basis o and manner st	f examination and/or i	th occurred at the time	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of ce ifier	000)	•	29c. Licens			d. Date signed (Mon	
) (C	200		30. Name and address of person w		death (Item 23a) (Type	Priller K	2) em	2 my 7	10/18/	<i>y</i>
	ກ <sub>ະ</sub> Sta	te	31. Date filed (Month, Day, Year)	1 mcM M	ar's Signature	stown r	<i>y</i> 4/6	1/0 11/6	-02,00	<b>v</b>
	Registr	ar	0612	0 2005	seve &	Dogally )				

State of Maryland / Department of Health and Mental Hygie $p_0$  0 535302 For State Ragistral Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** OCTOBER 13, 2005 **JESSIE** JOHNSON 1210 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CASEY HOUSE ROCKVILLE
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. MONTGOMERY 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 08-02-1918 SOUTH CAROLINA 1 ☐ M 2 💢 F 87 Yrs. Director 255-52-3144 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Show Itam 27 ie marked other then "natural", or Itema 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 XYes 2 □ No Director PRINCE GEORGE TEMPLE HILLS MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4206 21st. AVE 20748 U.S.A. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after to Department of Heelth and Mental Hygiene. I hours after important: If Itam 27 is marked other than "natural", or lee eny injury or other traumatic event the 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 4<del>+</del> NURSE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN DRUSILLA POWELL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CHARLES JOHNSON/SON 1350 ATWOOD RD SILVERSPRING, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State LINCOLN MEMORIAL CEM. 10-21-2005 CHATHAM, GEORGIA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER RD LANDOVER, MD 20785 D. ٨ Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part1, Enter the disease Immediate Cause (Final disease or condition **Physician** DEMENTIA /Medical resulting in death) Due to (or as a consequence of): Examiner METASTATIC MALIGNANCY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine been signed by the ettending physicien and should be detached for use as the burial-transit death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š of Vital Records, 24 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy hes rmed? 2 2 No 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes To the Hospital or Attending Physicien: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 10 Other (Specify) HOSPICE 1 ☐ Yes 2 X No ٩ 2 ER/Outpatient 3 DOA this cours after death. neral Director; After this filled in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: Injury Division 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place. 24 hours 29a. Certifier Medical within 24 hou To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES HARRISON MD, 6001 MUNCASTER MILL RD ROCKVILLE, MD 20855 31. Date filed (Month, Day, Year) Registrar's Signature State OCT 1 8 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 005 35303 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** OCTOBER ERMA A. JAMISON 2005 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CALVERT MANOR HEALTH CARE CENTER CECIL RISING SUN If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, 6-22- Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 🗶 F 202-16.2917 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a, State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 No RIJING SUN CECIL MD Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ROAD 1881 TELE GRAPH death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: WHITE δ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than BECOY SHIPPING DEPARTMENT DECO

18. Mother's Name (First, Middle, Maiden Sumame) 12 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill iment of Health and Mental H: tant: If item 27 is marked other. ANNIE VIOLET SPANGLER F. WISLER JOHN\_ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 26 DEER RUN RD. NOTTINGHAM #A 195
Date 20c. Location - City or Town, State LESTER C. JAMISON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Pages Department of Important: If it sny injury or o rtment of 10/19/2005 PEACH BOTTOM PENN HILL FRIENDS 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A. 21. Signature of Funeral Service License Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DEMENTIA - ALZHAMER TIPE Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the attending physician and thed for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☒ No 4☐ Pregnant at time of death 5 Cher (specify) 9 Unknown sate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 🗌 Yes 2 🗆 No this certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation death filled in by the Director 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number H53419 0 crobbal 2 2005 86 Name and address of person who completed cause of death (Item 23a) (Type, Print) RISING SUN, MD 1881 TRUMMAN ROAD. 1),0. , MAHINC MANGO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 8 2005 Registrar

			For State			partment of H	ealth and			35304
		a:	Registra MFND#8per IN  1. Decedent's Name (First, Middle,		,MOO	orimouto or i	Journ	2. Date of Dea		3. Time of Death
	Physici		Archibald Leopo	ld Virby				Month October		ear 05 4:03 P
	/Medic Examin		4a. Facility Name (If not institution,		)	4b. City, Town, or	Location of De		4c. County of	<del></del>
*			Washington Adve	ntist Hospi	ltal	Takoma	Park		Montgo	omerv
<u> </u>	Funeral		5. Social Security Number 6	i. Sex 7. A 1 ☑ M 2 ☐ F	ge (In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 H Hours Mi	rs. 8. Date of Birtl in. (Month, Day	10 <u>-</u> 2-1935°	Birthplace (State or Foreign Country)
城。	Director		267-57-5529	TXX M ZUF	70 Yrs.			-Oct.3,		Jamaica
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Mary	ţ	Maryland Prince	George's		Adelphi				1 ☐ Yes 2 📆 No
	r 28a	Director	10e. Street and Number	George 3		10f. Zip Code			10g. Citizen of Wha	at Country?
	th wit		1826 Metzerott	Road #205		20	783		Jamaica	9
	eme eme	Funerai	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S. 1:	3. Was Decedent of Hi	spanic Origin? n. Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race -	American Indian, White, etc.
36	or It	by Fu	1 Never Married 2 Marrie	If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:		Specify:	
Ö	be filed within 72 hours after death with the Maryland tal hygiene. Id other then "natural", or Iteme 23a or 28a-f show event. I're Medical Examinar must be notified at		3 ☐ Widowed 4 ☐ Divorced  15. Decedent's	Year or Dates		cedent's Usual Occupa	ation		16b. Kind of Busin	Bi Racial
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פָ	be filed within tal Hygiene. d other then "	Bec	17. Father's Name (First, Middle, La	ast)				lame (First, Middle,		
<u>Iar</u>	should b and Menta marked	2	Unknown K	irby			Unkno	wn		
Maryland 21215-0036	2 should be and Mental Is marked c	10	19a. Informant's Name/Relationshi	p (Type, Print)	19b. Ma	iling Address (Street a	and Number or	Rural Route Numbe	r, City or Town, Sta	ite, Zip Code)
2,5	D = N = D		Emlyn R. Kirby	Wife		Metzeroti	t Road			land <u>20783</u>
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 eny injury or other 2008.		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3	B □Removal from State	cemetery, c	position (Name of rematory or other place	e)	Date	20c. Location - Cit	y or Town, State
tim	tmen tant:		4 □ Donation 5 □ Other (Spe		Metropol	Crematery	Oct	.16,2005	Alexandri	a,Virginia
Bal	Deparming Department of the partment of the pa		21. Signature of Funeral Service Li	censee	I	Crematery 22. Name and Ad es rancis J.	Collins	s Funeral	Home, In	ıc.
40			23a. Part 1 Enter the disease, or c shock, or heart failure. List o	omplications that cause	ed the death. Do not	000 Univers	sity Bl	vd.,W.,Si	lver Spri	ng MD 20901
			shock, or heart failure. List of Immediate Cause (Final	nly one cause on each	line.	511561	,			Interval Between Onset and Death
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90,	the death certificate be executed y the attending physician and tched for use as the burial-transit	Ä	resulting in death) Last	Due to (or a	s a consequence of);					
8760,	cate be ex physician the buria	dicai		d						
9 x	eath certific attending p	Physician/Me	IF FEMALE:	23c. If yes, outcom	e of pregnancy				23d. Date of	of delivery
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P.O.	that the d ed by the detached	hysi	9 Unknown	9□ Unknown						
	res tha igned to be det	by P	Part II. Other significant condition						bacco use contribu	ute to the cause of death?
ord	v require been si should b	0	DIABETES	HYPE	GIENSION	/		1 O Y	es 2□No 3[	Probably 4 Unknown
Division of Vital Records,	2 5 8	Complete	HYPERLIPI.	DEMIA	CONCEST	IVE HEAD	7 FAIW	24a. Was a		re autopsy findings available or to completion of cause of
<u> </u>		Con		/				penor		ith? Yes 2□No
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examinet?	Hospital:		100		eath (Check only or	(e)	
of	S D	To	1 Yes 2 No 27. Manner of Death	28a. Date of In			4 🗆 (40/3///9	Home 5 Resid	ence 6 Other ow injury occurred	'Specify)
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á	s after	Certification:	4 Homicide determin	building,	etc. (Specify)			City or Tow	n, State)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying	Physician: To the bes	t of my knowledge, de	ath occurred at the tim	ne, date and pla	ice, and due to the d	cause(s) and mann	er as stated.
	the H iin 24 the Fi	ledical	one)	and manner						
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier	ho		29c. License			29d. Date signed (#	•
7	6			- 0		0470	55		OCTOBER	13, 2005
	4		30. Name and address of person w	4-11	death (Item 23a) (Typ	e, Print)	1	- d	201- M	1. 20912
39	Sta	ite	31. Date filed (Month, Day, Year)		7600 (trar's Signature	MAKOII A	16. 11	HOOMA /	HRK_//0	1. 20712
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	12. Was Decedent E Armed Forces? 1   Was Decedent E Armed Forces? 1   Was Decedent E Armed Forces? 1   Was Give Year or Dates: Education rade completed) College (1-4or 5-1) Roy (Type, Print) and Son	Morial 81 Y 10c. City, Town Davis Ever in U.S. 40 16a. I 20b. Place of I cometery Roy C	or Location  or Location  10f. Zi  2  13. Was Decer If Yes, spe 1 Yes  Decedent's Usi Give kind of wind Lister Do NoT is  Memo Disposition (Na, crematory or Cemete:	ip Code 6260  dedent of Hispanic Coecify Cuban, Mexic  22 No Special  all Occupation ork done during more done during more sectored)  k  18. Mot Mar  ss (Street and Num  rial DR  time of other place)  ry	er 24 Hrs. 8. Date of Min. 0 3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10g. Citizen of WUSA  No-  14. Race Black Specify  16b. Kind of Bu  Restau  Wymer  nber, City or Town, 3  20c. Location - 1	9. Birthplace (State or Foreign Country)  10d. Inside City Limit Naves 2 No No Note 2 No No No No No No No No No No No No No
nce of Decedent  10b. County  Tucker  1 Street  Ind Number  1 Street  Industry  Indust	12. Was Decedent E Armed Forces? 1   Yes 2   Wester   If Yes, Give Year or Dates: Education College (1-4or 5-4) If Yes, Give Year or Dates: Education College (1-4or 5-4) If Yes, Give Year or Dates: Education College (1-4or 5-4) If Yes, Print; If	81 Y  10c. City, Town Davis  Ever in U.S. do  16a. I  19b. 28  20b. Place of I cemetery Roy C	or Location  101. Zi  2  13. Was Decell'Yes, spe 1 Yes  Deceder's Use Give kind of we life. DO NOT to COO  Mailing Address  Memo Disposition (Na., crematory or Cemete:	ip Code 6260 edent of Hispanic Certify Cuban, Mexic 22 No Special and Occupation or done during means a retired) k  18. Mot Mar ss (Street and Num rial DR time of other place) ry	Origin? (Specify Yes or can, Puerto Rican, etc.)  ost of working  ther's Name (First, Middle Sie Mary other or Rural Route Nur.)  Parsons Date	10g. Citizen of WUSA  No-  14. Race Black Specify  16b. Kind of Bu  Restau  Wymer  nber, City or Town, September, City or Town, September, City or Location - 10 control of the september of the	Ind. Inside City Limit NOYes 2 □ N  What Country?  e - American Indian, k, White, etc.  White siness/Industry  rant e)  State, Zip Code)
Tucker  Ind Number  In Street  Intustive of Married 2 Married  Intustive of Married 2 Married  Intustive of Married 2 Married  Intustive of Married 2 Married  Intustive of Disposition  Intustive of Married  Intustive of	12. Was Decedent E Armed Forces?  1	Davis Ever in U.S. do  16a. (  19b.   28  20b. Place of I cemetery Roy C	10f. Zi 2 13. Was Dece If Yes, spe 1   Yes Coo  Mailing Addres Memo Disposition (Na, crematory or Come te	deent of Hispanic Cecify Cuban, Mexic  2 No Specification or k done during months done during months are retired)  18. Mother Mar  ss (Street and Num  rial DR  ame of other place)  ry	ther's Name (First, Midding of Parsons  Date	USA  No-  14. Race Black Specify  16b. Kind of Bu  Restau  Ille, Maiden Sumanu  Wymer  Inder, City or Town, Sumanu  WV 26.	what Country?  e-American Indian, k, White, etc.  White siness/Industry  rant e)  State, Zip Code)
r Married 2 Married wed 4 Divorced  15. Decedent's E (Specify only highest gr WSecondary (0-12)  Name (First, Middle, Las  SON Neil nt's Name/Relationship  Furner/gra of Disposition at 2 Cremation 3 [ ation 5 Other (Special) ation 5 Other (Special) ation 5 Service Lice of Funeral Service Lice contert the disease, or contert the disease, or conterts	Armed Forces?    Yes 2   2   2   2   2   3   3   3   3   3	19b. 19b. 28 20b. Place of Cemetery, Roy C	13. Was Deceil Yes, spending the Memo:  Mailing Address  Memo:  Disposition (Na., crematory or Cemete:	edent of Hispanic Cecify Cuban, Mexic  2 No Specifical No Specifical Occupation or onk done during muse retired)  k 18. Mot Mar  ss (Street and Num  rial DR  mme of other place)	ther's Name (First, Midding of Parsons  Date	No-  14. Race Black  Specify  16b. Kind of Bu  Restau  Ide, Maiden Sumami  Wymer  Inber, City or Town, Sumami  WV 26	k, White, etc. White siness/Industry  rant e)  State, Zip Code)
15. Decedent's E (Specify only highest gray (0-12)  Name (First, Middle, Last Son Neil nt's Name/Relationship of Disposition at 2 Cremation 3 (ation 5 Other (Special of Fyneral Service Lice of Fyner	Year or Dates: Education rade completed)  College (1-4or 5-4)  Roy (Type, Print) andson  Removal from State ify)  ansee  molications that caused	19b. 28 20b. Place of I cometery Roy C	Decedent's Using Cooperation of the Cooperation of	ual Occupation ork done during me use retired)  k  18. Mot  Mar as (Street and Num  rial DR  ume of other place)	ost of working  ther's Name (First, Midding ie Mary ober or Rural Route Nur  Parsons Date	Restau  Restau  Wymer  The City or Town, September, City or Location	rant e) State, Zip Code)
rson Neil  nt's Name/Relationship  Furner/gra  of Disposition  al 2 Cremation 3 [  ation 5 Other (Special of Funeral Service Lice	Roy (Type, Print) andson  Removal from State ify)  Polications that caused	20b. Place of I cemetery Roy C	Mailing Addres Memo: Disposition (Na., crematory or Cemete:	18. Mot Mar is (Street and Num rial DR ume of other place)	gie Mary  Deer or Rural Route Nur  Parsons  Date	Wymer  nber, City or Town, WV 26.	e) State, Zip Code) 287
Curner/gra of Disposition al 2 Cremation 3 Cation 5 Other (Special of Fyneral Service Lice	Removal from State ify) ansee  molications that caused	20b. Place of I cemetery Roy C	Memo: Disposition (Na., crematory or Cemete:	rial DR ame of other place) ry	. Parsons	WV 26	287
of Funeral Service Lice	mplications that caused	Extra		-	10/16/05	Dear Lan	
Enter the disease, or con or heart failure. List only	mplications that caused y one cause on each line		P.O.	le Fune Box 18	ral Home, 6 Davis,		rk, WV O
cause (Final ondition leath)	a. Iteya	the death. Do not let the death. Do not let	nnl	-	as cardiac or respiratory	rarrest,	Approximate Interval Between Onset and Death
list conditions, g to in red late r Underlying ase or injury events eath) Last	b. Cirrhos Cue to (or as a	sis of t	he LIve	er			years
cedent pregnant ast 12 months? s 2 No known	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at the 10 Unknown	2 Fetal death	3 □Ectopic p 5 □ Other (s			23d. Date Mon	e of delivery hth Day Year
significant conditions	contributing to death bu	ut not resulting in t	the underlying	cause given in Par			ibute to the cause of death? 3 Probably 4 20nknov
e referred to medical				26 Pla	pe 1 ☐ Yes	topsy proformed? do	Vere autopsy findings availabrior to completion of cause of eath?  ☐ Yes 2☐ No
? 2 No If Death ral 5 Pending dent investigation	28a. Date of Injury (Month, Day	V		OA Other: 4 1 1 28c. Injury at Work?	Nursing Home 5 Re	sidence 6 Othe	
	building, etc.				City or 1	own, State)	
· · · · · · · · · · · · · · · · · · ·	iminer: On the basis of a	examination and/	or investigation	n, in my opinion, de	eath occurred at the tim	e, date and place, a	nd due to the cause(s)
Medicel Exa			29		1.64		Dance Mila
	? 2 No if Death ral 5 Pending dent investigate ide 6 Could not determined  2 Medicel Exe	Ponly 2 Moore Hospital: 1 In Impatier  1 Death In Impatier  28a. Date of Injur (Month, Day determined)  28b. Place of Injur building, etc.  28c. Place of Injur building, etc.	Hospital:   Minpatient   2   ER/Outp	Hospital: 1 Impatient 2 ER/Outpatient 3 D  If Death ral 5 Pending investigation lide 6 Could not be determined 28e. Place of Injury (Month, Day Year) 28b. Time of Injury M  28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)  29 Medicel Examiner: On the basis of examination and/or investigation and manner stated.	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 1 1 Peath ral 5 Pending investigation ide determined 1 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, dare and title of certifier 29c. License number 1 Peace of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, dare and title of certifier 29c. License number 1 Peace - At home, farm, street, factory, office building, etc. (Specify) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, dare and title of certifier 29c. License number 1 Peace - At home, farm, street, factory, office building, etc. (Specify) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, dared and title of certifier 29c. License number 1 Peace - At home, farm, street, factory, office building, etc. (Specify) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, dared and manner stated.	Hospital:   Minpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Reference	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other work?  If peath ral of pending investigation determined of Could not be determined of Could not b

			1 - For State Registrar	State of Maryland /	Department of F Certificate of		Hygiene 0 0	5 35306
Ĭ	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last)     Conclusion (First, Middle, Last)     A. Facility Name (If not institution, give st.)	P. KUN7			of Death th Day ODE 16 6	3. Time of Death (ceer 05/0 M
	Funeral Director	e i	Ancwrage NUIS 5. Social Security Number 146-01-9640 10	m 215/F Rehab 7. Age (In yrs. last to	Salls  birthday) If Under 1 Year  Months Days	If Under 24 Hrs. 8. Date (Mor 3/1		9. Birthplace (State or Foreign Country) New Jersey
	Maryland a-f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Wicomico		wn or Location			10d. Inside City Limits 1 ☐ Yes ※☐ No
	with the 3s or 28	I Directo	10e. Street and Number 31522 Spearin Rd		10f. Zip Code 2180	4	10g. Citizen of WI	nat Country?
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural, or items 23s or 23s-f show aumatic event, the Medical Exactinat must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 _ Yes _ 2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Specify Yes an, Mexican, Puerto Rican, e Specify:		- American Indian, , White, etc. white
21215-0036	d within 72 ho giene. er then "natur , the Medicul.	Completed by	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation 16 completed) 16 College (1-4or 5+) —	a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired Homemaker	ation during most of working d)	16b. Kind of Bus	
Maryland 21	d tal	To Be (	17. Father's Name (First, Middle, Last) Edwin F. Payne			18. Mother's Name (First, I Eliza Ande		)
	nd 2 should be Ith and Mental 27 is marked o		19a. Informant's Name/Relationship (Type Sandra J. Schirner		9b. Mailing Address (Street 31522 Spear	and Number or Rural Route in Rd., Salis	Number, City or Town, S bury, MD 21	itate, Zip Code) 804
ore,	Pages 1 ar nent of Hea int: If item ? iry or other		20a. Method of Disposition 1 ☐ Burial 2 【※Cremation 3 ☐ Re	emoval from State	of Disposition (Name of tery, crematory or other place	30/30/05		City or Town, State
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men important: If item 27 is marke eny injury or other traumatic ODEs.		21. Signature of Funeral Strvice Licensee		Holloway 501 Snow I	ry 10/18/05 funeral Home H Hill Rd., Sal	Salisbu Professiona isbury, MD 2	l Association
68760,	/Medical Examiner bhisician and briansit sthe burial-transit	dical Examiner	23a Part. Enter the disease, or complic shock, or heart failure. List only one time-diate Cause (Finat disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Figure that initiated events resulting in death) Last  d.	Due to (or as a consequence	re of):	ig, such as cardiac or respire	arest,	Approximate Interval Between Onset and Death
Division of Vital Records, P.O. Box 6	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Sc. If yes, outcome of pregnancy  1 Live birth 2 Fetal dea  4 Pregnant at time of death  9 Unknown		y	23d. Date Mont	of delivery th Day Year
rds, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions cont	tributing to death but not resulting	g in the underlying cause giv	ven in Part I. 236		bute to the cause of death?
al Reco		Completed			ILURE	1	autopsy pr performed? de Yes 2 No 1	ere autopsy findings available ior to completion of cause of sath?  Yes 22 No
of Vit	Physician: r this certifica ral director,	To Be	1 165 2 2 1/10	ospital:		26. Place of Death (Check	Residence 6 Othe	
ion o	Attending P ir death. ector: After by the funera	atlon	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	injury M 28c. Injury Wor	ry at rk?   Yes 2   No	scribe how injury occurre	a
Divis	in Si the of	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)		City	or Town, State)	r or Rural Route Number,
	To the Hospitel or within 24 hours after To the Funeref Dir completely filled in	edical		ician: To the best of my knowled er: On the basis of examination and manner stated.	and/or investigation, in my o	opinion, death occurred at the	e time, date and place, a	nd due to the cause(s)
)	with.	Σ	29b. Signature and title of certifier	4.D.	29c. Licens D 5	7 9 5 2	- ·	(Month, Day, Year)
	4 mg		30. Name and address of person who cor	101 Wilfor	a) (Type, Print)	SYB SAL		
	Sta Regist		31. Date filed (Month, Ray, Year)	32. Registrar's Signature	Locale			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#22, perDVR C849 11-1-05 TT

State of Maryland / Department of Health and Mental Hygiene 0 5 35307 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** DE FORD 11 2005 LARRIMORE OCTOBER RENE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner NURSINE & REHAR CENTER HESTERTONN HESTERTOWN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min 1 M 2 F 217 093654 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State or 28e-f show other traumatic event, the Medical Exeminer must be notified at KENT 1 Yes 2 No Rock MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A 5690 SOUTH 21661 MAIN Items 23a Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No ŏ Specify: WHITE 3 Widowed 4 □ Divorced 'natural' 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) than RESTAURANT 10TEL OPERATOR OWNER 12 other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DEFORD Is marked DAISY CRANE GEORGE COLLYER ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 118 CEDAR CHESTERTOWN, MD 21620 W. ROGER WILLIAMS 20c. Location - City or Town, State 2/6 20 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages Department of Importent: If it any injury or o 1 Surial 2 Cremation 3 Removal from State 10/14/05 CHESTERTOWN, MD CHESTER \* 4 ☐ Donation 5 ☐ Other (Specify) CEMETERY 22. Name and Address of Facility Marvin V. Williams Pineral Director 21. Signature of Fyneral Service Licensee M00621 avai 216 MD CHESTERTOWN 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** CARDIO pulmonary resulting in death) /Medical Due to (or as a consequence of): **Examiner** poteusion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) **burial** the attending physician Completed by Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h Was decedent pregnant 1 Live birth 2 Fetal dea 4 Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Year ŏ in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? . be 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 2 No 2 🗆 No certificate 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ۵ 1 Inpatient 3 DOA 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred after death.

Director: After t Medical Certification: 5 Pending investigation 1 Natural Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 😿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the To the 29b. Sign to and title of certifier 23889 who completed use of death (Item 23a) (Type, Print) 2)5 223 thigh Street, Chester Foun Wed 21620 John C. ARKABAC

State Registrar 31. Date filed (Month, Day, Year)

Baltimore, Maryland

Box 68760,

o

Division of Vital Records,

M. M.1). 32. Registrar's Signature

2005

				partment of Health and Nertificate of Death	Mental Hygier Reg. l	Z U U D - 3 D 3 U D -
		7.	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death
	Physicia /Medic		Cornelia E. Ludewig		October 1	
3	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	8 (3)		Beverly Healthcare  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Frederick  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Frederick
	Funeral Director		1 □ M 2 💢 F 72 Yrs.	Months Days Hours Min.	(Month, Day, Yea	
22-			253-46-4798 Usual Residence of Decedent		July 14,	1933 Georgia
	how thow	_	10a. State 10b. County 10c. City, Town or			10d. Inside City Limits 1 ★Yes 2 No
	8a-f	ecto		ederick	1.0	21
	Meth to	E C	10e. Street and Number 707 Wyngate Drive	10f. Zip Code 21701		Citizen of What Country? .ted States
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If the Arranked other than "netural", or iteme 23a or 28a-f show other traumatic event, the Madical Examinat must be notified at	Funeral Director				14. Race - American Indian,
	r iter d	필	1 Never Married 2 Married 1 1 Yes 2 1 No 1 1 Yes 2 1 No 1 Yes 2 1 Yes	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
2-003c	72 hours after netural', or ite dical Examine	þ	3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: White
ה ה	72 h	Completed	(Specify only highest grade completed) (G.	cedent's Usual Occupation ive kind of work done during most of work	king 16b.	. Kind of Business/Industry
7	within ene. than T	ig i	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retired)		Automotive
N	e filed within al Hygiene. I other than vent, the Me		17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid	
_	id be ental ked o	To Be	Albert S. Norton	Effie '	Maffett	
ary	2 should be 2 should be n and Mental 1s marked c raumatic ev			ailing Address (Street and Number or Rui		y or Town, State, Zip Code)
2	and 2 salth a n 27 ls		David W. Ludewig / Husband 707	Wyngate Drive, Fr	ederick, M	D 21701
<u>e</u>			20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition cemetary, compared to the compared to t	sposition (Name of crematory or other place)	Date 20c.	Location - City or Town, State
Ě	permit. Pages Department of Importent: If It any Injury or o		4 Donation 5 Other (Specify) Stevens			nroe Township, PA
Salt	Departi Departi Import any Inj pnce.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility St. 1621 Opossumtown		
	20 = a a	Н	on they saufley	<u> </u>		
			23a. Ranti Enter the disease or complications that cause the death. Do not shock, or heart failure. List only one cause on each line.		or respiratory arrest,	Approximate Interval Between Onset and Death
),,	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Hydrogen and the properties of the properti	eloma		4 months
	Examiner					
27.	A . 5	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	cuted nd ransit	Examiner	that initiated events C.			
Š	be executed icien and burial-transi	EX	resulting in death) Last Due to (or as a consequence of):			
2/PC	ate the	dicai	d.			
٥ ×	that the death certificate ed by the attending phys detached for use as the	0	IF FEMALE: 23c. If yes, outcome of pregnancy			and Date of delices
X P P	death c	Physician/M	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery  Month Day Year
oj.	the d	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	o a out of tapoonly/		
7	requires that the een signed by th hould be detache		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
202	w requires that been signed to should be det	ed t	End Stage renal directe		1 ☐ Yes	2 No 3 Probably 4 □Unknown
ပ္က		Completed by	Coronary artery disease		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
ř	The I	mo;			performed	? death?
Vital H	eicien: The law s certificete has t lirector, page 2 s	Be (	25. Was case referred to medical examiner?		th (Check only one)	
5	ding Physicien: h. After this certific funeral director,	ဥ	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa			6 ☐Other (Specify)
ב	Jing F	lon	27. Manner of Death 1 ☑Natural 5 ☑ Pending 28a. Date of Injury (Month, Day Year) Injur		28d. Describe how in	jury occurred
Division	otor: y the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,		28f. Location (Street	and Number or Rural Route Number,
2	after after Dire	erti	4 Homicide determined building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	City or Town, St	ate)
	spits hours ineral y filler	aiC	29a. Certifier 1 Certifying Physician: To the best of my knowledge, do	eath occurred at the time, date and place.	and due to the cause	o(s) and manner as stated.
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/o and manner stated.	investigation, in my opinion, death occur	rred at the time, date a	and place, and due to the cause(s)
	Vilhi Vilhi To ti	2	29b. Signature and title of certifier	29c. License number	3	Date signed (Month, Day, Year)
)			I Groven Stryn Stil Mi	D. D0047679	7	0-19-05
	C		30. Name and address of person who completed cause of death (Item 23a) (Type 23a)	pe, Print)	Cala I	
			31. Date filed (Month, Day, Year)  OCT 19 2005	laver (UT # 105,	- LIEUTENICE	, MD 21+05
	Sta Registr		OCT 1 9 2005 Men &	Coule		

			1 ⊶ For State Registrar	State of Mary			nt of H te of I			F	Reg. No.	35309
	Physici /Medic	_	1. Decedent's Name (First, Middle, Last)	CATTL	)					Month Dea	16 300	3. Time of Death 1:35A M
	Examin Funeral	er	4a. Facility Name (If not institution, give s  COASTAL HUST  5. Social Security Number 6. Sex	1CE AT	JAKE n yrs. last birthday	0	AL er 1 Year	If Under 2	IRY	Date of Birtl	4c. County of I	Birthplace (State or Foreign Country)
×	Director		103-18-5215 Usual Residence of Decedent 10a. State 10b. County		84 Yrs.				04	4-23-1		New York  10d. Inside City Limits
	Ba-f ehow	ector	Delaware Sussex		Seaford							1X Yes 2 □ No
	with t	Dir	10e. Street and Number 727 Rosetree Lane			101. 2	ip Code 1997:	₹			10g. Citizen of Wha	it Country?
980	s 1 and 2 should be tiled within 72 hours after death with the Maryland if health and Mental Hygiene. item 27 is marked other than "natural", or iteme 23s or 28s-f ehow other traumatic event, the Medical Examinar must be nutified at	by Funeral Director		2. Was Decedent Eve Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: 19			edent of H ecify Cuba		in? (Specif Puerto Ric	y Yes or No- can, etc.)		American Indian, White, etc. White
21215-0036	i within 72 hou jene. r than "natura the Med Fall	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Giv life.	e kind of v	use retired	furina most :	of working		16b. Kind of Busin	
Maryland 2	12 should be tiled within 7 h and Mental Hygiene. 7 Is marked other than " fraumatic event, the Med	To Be C	17. Father's Name (First, Middle, Last) Costeritino Locat	to					(1)	First, Middle, 1KNOWN	Maiden Sumame)	
Mary	nd 2 shou lith and N 27 is mar r traumal		19a. Informant's Name/Relationship (Ty) Roseann Zabel - Kjo			•					r, City or Town, Sta E 19973	te, Zip Code)
Baltimore,	8 = 5		20a. Method of Disposition  1 Burial 2 💆 Cremation 3 R  4 Dopartion 5 Other (Specify)	Chann	20b. Place of Disp cometery, cri Capitol	ematory of	other plac	10	Dat 0-20-0		20c. Location - Cit Dover, D	
Balti	permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service Licens	Much		Crar P O	and Address ston Box	Funer	al Ho Seafor	ome cd, DE	19973	
8760,	Physician / Medical Examiner	dicai Examiner	23a art1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	END S Due to (or as a co	onsequence of):  IHBIMIN onsequence of):	R	ZNA		DE	SRA		Approximate Interval Between Onset and Death
.O. Box 6	death certific e attending p od for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of p 1 Live birth 2 C 4 Pregnant at tim 9 Unknown	Fetal death 3	□Ectopic □ Other (	pregnancy specify)				23d. Date o Month	f delivery Day Year
Ω.	S L 9		Part II. Other significant conditions con	tributing to death but n	ot resulting in the	underlying	cause give	en in Part I.		23e. Did to	1	te to the cause of death?  Probably 4 Unknown
Division of Vital Records,	The law ate has b page 2 sl	Completed				-			_	24a. Was autop perfor 1 Yes	meg/ dea	e autopsy findings available r to completion of cause of th? Yes 2 No
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	0 C 5 D 10		Oth			Check only o		Specify HOSPICIZ
on of	Jing Atter	tion; To	1 Yes 2 No  27. Manner of Death  Shatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	2 ER/Outpation 28b. Time Injury		28c. Injun World		280		low injury occurred	Specify PTOS P7C12
Divisi	al or Atter s atter dea il Director od in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (5	- At home, farm, s Specify)	street, facto	ory, office		28	f. Location (S City or Tow	Street and Number on, State)	or Rural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely tilled in by the	edicai	29a. Certifier (Check only one)  2 Gertifying Physical Examination	sician: To the best of mer: On the basis of ex and manner stated	amination and/or	ath occurre	d at the tin	ne, date and pinion, deatl	d place, and h occurred	d due to the d at the time, d	cause(s) and manne date and place, and	or as stated. due to the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier			2	9c. Licens				29d. Date signed (A	
•	5+1 UK		30. Name and address of person who co	mpleted cause of deat				0521	110		10/1	6/05 BURY WD. 2180
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's		ARK	20W	app	C	Ti	GALISI.	34Rymp. 2180

State of Maryland / Department of Health and Mental Hygiege 0 0 5 35310 For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2005 MICHAEL Κ. McHENRY October | 24 10:01 a<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 600 I St. Mt. Lake Park Garrett If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1X M 2 ☐ F Yrs. 213 78 4793 Director 45 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural" ~~~ any injury or other traumatic avorations. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Garrett Mt. Lake Park 1 □XYes 2 □ No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 600 I Street 21550 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Loan Underwriter Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Spurrier Helen James McHenry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Van Dyk 6520 Mink Hollow Rd. Highland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation \_5 ☐ Other (Specify) Cumberland Crematory Oct 25 05 Cumberland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burdock/Durst FH 21 N. 2nd St. Oakland, MD 21550 WOODS 23a. Part? Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arteriosclerotic coronery vascular disease Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 🗌 Unknown certificate has been signed by i rector, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 Yes Hospital or Attending Physician: tor: After this certific the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 es 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H26154 mund Oct 24,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. Daniel Miller 69 Wolf Acres Dr. Oakland, MD 21550 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2005 Registrar

Amended Item #2 per physician, 10/26/05 cs

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Maryland / De	partment of Health and Me	ntal Hygienen n =	353
C	ertificate of Death	Beg No	000

YSI	cian, i	07	26/U5 CS 1 = For State Registrar	State of Ma		epartment of Certificate of	Health and N Death		iene 0	5 3	35311
	Physic /Medi		Decedent's Name (First, Middle, Last)     ETA	M.	MUR	PHY		2. Date of Deat Month		2005 1974	3. Time of Death 4:15 P M
1	Exami		4a. Facility Name (If not institution, give to 615 Weatherly Rd.			Bel Air	or Location of Death		4c. Count		
	Funeral Director		5. Social Security Number 6. Sep 214-07-6866	7. Age	(In yrs. last birtho	Months Days		8. Date of Birth (Month, Day, Feb. L,	<sup>7</sup> 1914	9. Birthpl Count Mary	ace (State or Foreigr try) Land
	h the Maryland r 28e-f show	tor	10a. State 10b. County  MD Harford	1	10c. City, Town o	r Location				10	0d. Inside City Limits
	death with the Maryland ms 23a or 28e-f show [must be notiff, d.:]	Funeral Director	10e. Street and Number 615 Weatherly Road			10f. Zip Code 21015		10	0g. Citizen of	What Count	
36	after or Ita		11. Marital Status 1 □ Never Married 2 🔀 Married	12. Was Decedent E Armed Forces? 1 Yes 2X No		I3. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Rad Bla	ce - America ck, White, e	ın Indian, itc.
15-0036	72 hc	Completed by	3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grade)	Year or Dates: cation completed)	(G	ecedent's Usual Occu		ing	Specif	Whi	
Maryland 2121	e filed within al Hygiene. I other than 'vant, II har	Be Comp	Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, Last)	College (1-4or 5+	-)	emaker	18. Mother's Name		Own H		
arylar	should band Ments smarked	To E	Asa Rush 19a. Informant's Name/Relationship (Type	oe, Print)	19b. M	ailing Address (Stree	Iva Frien		City or Town,	State, Zip (	Code)
	m 0		Ralph Murphy/Husbar		615		Rd., Bel	Air, MD	21015		
Baltimore,	permit. Page: Department of Important: If i any injury or once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ R.  4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License		Bloomin	g Rose Cer 22. Name and Addre	netery Oct ess of Facility Ne 275, Grant	wman Fun	neral H		
68760,	Medical Examiner  Thysician and is the buriat-transit	edical Examiner	23a. Part1. Enterthe disease, or complications, of peart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	he death. Do not all a consequence of):  consequence of):  consequence of):		ng, such as cardiac c	r respiratory arre	st,	1	Approximate interval Batween Onset and Death
O. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal death	3 ☐Ectopic pregnanc 5 ☐ Other (specify)	у		23d. Dat	e of delivery	/ Day Year
Records, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions conditions		not resulting in the	underlying cause gru	ren in Part I.	23e. Did toba			cause of death?
tal Rec		e Completed	25. Was case referred to medical						ed? d ≥No 1	Vere autops rior to comp leath? Yes 2	y findings available pletion of cause of
Division of Vital	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely illied in by the funeral director.	Certification: To Be	examiner?	ospital: 1 □ Inpatient 28a. Date of Injury (Month, Day ) 28e. Place of Injury building, etc.	Year) 28b. Time Injury	of 28c. Injur Wor	y at 2 k? Yes 2 □ No		ce 6 Other	ed	Route Number,
D	Hospital of the spital of Funaral Distribution in the spital of the spit	Medical Cer	29a. Certifier (Check only one)  Certifying Physical Examination	cian: To the best of e	my knowledge, de xamination and/or	ath occurred at the tir	ne, date and place, a pinion, death occurre	nd due to the cau	(so(s) and ===	nner as state	ed.
	To the within ?	Mec	29b. Signature and title of certifier	and manner state		29c. Licens		290	d. Date signed		
	4	3	ame and address of person who con	npleted se of dea	th (Item 23a) (Typi		e 10 ±		Selffi	7/2 - MC	21015
	Sta Registr		31. Date filed (Month, Day, Year) OC 2 4 20	32. Registrar's	o Signature	And					
DH.	MH 17 Rev 1/20	01									

State of Maryland / Department of Health and Mental Hygiene 200535312 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day 2005 Year William Thomas Maddox, Jr. Oct. 15. 10:30 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Civista Medical Center LaPlata MD Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 9. Birthplace (St. Months Days Hours Min. March 20,1936 Mary Land 5. Social Security Number 6. Sex 1 → M 2 → F 7. Age (In vrs. last birthday) **Funeral** 69 Yrs 218-30-3499 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other then "natural", or Items 23a or 28a-f show other traumatic event. The Madical Examinar must be notified at 1 ☐ Yes 2 XNo Completed by Funeral Director Maryland | Charles Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5385 Stuckey Road 20640 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Ž☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 X No Specify. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed within and Mental Hygiene. Pipe Fitter D.C. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Thomas Maddox, Sr. Mary Goldie Ashton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) tem 27 Wife Deloris Maddox 5385 Stuckey Road, Indian Head, Md. 20640 20a. Mathod of Disposition

1 🖰 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other placect. 20,2005 20c. Location - City or Town, State ō = 6 permit. Page Department of Important: If any Injury or once. St. Charles Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Indian Head, Maryland <sup>22. Name and Address of Facility</sup>
Williams Funeral Home, P.A.
4270 Hawthorne Rd., Indian Head, Md. 21. Signature of Funeral Service Licensee M00668 23a. Part1. Enter the disease, or compleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Sause (Final Physician Acute Respiratory disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Septic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Cancer IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? the funeral director, page 2 autopsy performed? 1 Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of confrier. 29c. License number 29d. Date signed (Month, Dav. Year) D-28035 10/16/ 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Basirmohmad F. Kolia, MD, 9135 Piscataway Rd. Ste 210, Clinton, MD 20735 31. Date filed (Month, Day, Year) 32. Prigistrar's Signature State OCT 1 9 2005 Registrar

DHMH 17 Rev 1/2001

Jilliam

State of Maryland / Department of Health and Mental Hygiene 0 0 5 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 12,2005 4:39ат м Physician Maurer Christine /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Laurel Regional Hospital 8. Date of Birth (Month, Day, Year) Laurel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country)
3. Chicago IL 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1943 1 ☐ M 2 💢 F 62 Director 352-34-4951 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County or 28a-f show other than "natural", or Items 23a or 28a-f shower, the Medical Examiner sust be notified at 1 Yes Z No Crownsville Anne Arundel MD Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21032 1400 Lower View Court Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry during most of working Elementary/Secondary (0-12) College (1-4or 5+) Law Paralegal 08 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Importent: If tem 27 is marked other any injury or other traumatic event, 2006. 17. Father's Name (First, Middle, Last) Be Aniella Jendrusiak Stanley ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2106 Elm Street Hays Kansas 67601 James Maurer Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2☐Cremation 3 ☐Removal from State 4 ☐Donation 5 ☐ Other (Specify) Baltimore, MD 10-13-05 Metro Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home P.A. 12 Ridgely Ave ANN, MD all 23a. Part1. Enter the desease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Septic Shock Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): iner burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): physicien Physician/Medical es the l attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 2 No 3 ☐ Probably 4 ☐Unknown Cardiomyopathy been sign Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Congestive Heart Failure autopsy performed? Yes 2 No this certificete has al director, page 2: Renal Failure 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 0 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Cath 28c. Injury at Work? After Certification: T Natural 5 Pending 1 ☐ Yes 2 ☐ No s efter death. 2 Accident investigation completely filled in by the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) efter 4 - Homicide ö within 24 hours e To the Funeral 6 the Hospitel Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Braminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number 2 6201 GreenheltRCl, Sule 4-15 College PR M) 20740 person who completed cause of death (Item 23a) (Type, Print) - IKechi Feel OKWARA 32. Registrar's Signature State OCT 1 4 2005 Registrar

			1 - For State of Maryland / De State of Maryland / De	epartment of Health and M Certificate of Death		e <u>p</u> e() (	35314					
	Dhusis		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death					
	Physic: /Medi		Agnes Evelyn Myles		October	14, 200						
	Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of	Death					
			Anne Arundel Medical Center	Annapolis		Anne i	Arundel					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Days Hours Min	8. Date of Birth (Month, Day, 1–3–1917	Year)	Birthplace (State or Foreign Country)					
	Director		224-07-3737 88	. ,	1-3-1917		Virgínia					
	and *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of	r Location			10d. Inside City Limits					
	faryli sho	ō					1 Tes 2 No					
	the A	ect	Maryland Anne Arundel  10e. Street and Number	Riva	10	- Chi-						
	with	급	_	10f. Zip Code 21140	10	g. Citizen of Wh US						
	eath	by Funeral Director	2837 White House Rd.  11. Marital Status  12. Was Decedent Ever in U.S.									
	iten d	Š	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 Married  11. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 Mo	<ol> <li>Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto</li> </ol>	Rican, etc.)		American Indian, White, etc.					
36	irs af	by	3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 🛣 No Specify:		Specify:	White					
21215-0036	72 hours after death with the Maryland neturel', or Items 23a or 28e-f show disal Examinat must be notified at	per	15. Decedent's Education 16a. De	ecedent's Usual Occupation	10	Sb. Kind of Busi						
715	within 73 ene. then "n	Completed	(Specify only highest grade completed) (College (1-4or 5+)	ive kind of work done during most of worki e. DO NOT use retired)	ing		,					
212	d with	mo:	11th	Homemaker		Home	9					
	il Hygie other	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	iden Sumame)						
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ary	s ma	7	19a. Informant's Name/Relationship (Type, Print) 19b. M	aiting Address (Street and Number or Rura	al Route Number, (	City or Town, St	ate, Zip Code)					
	1 and 2 Health a lem 27 is		Bernard G. Myles/ Husband 283	7 White House Rd.,	Riva. MD	21140						
Baltimore,	of He item	11 3	20a. Method of Disposition 20b. Place of Disposition	sposition (Name of crematory or other place)			ty or Town, State					
Ĕ	permit. Pages 'Department of H importent: If ite eny injury or of		1 □ Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 🛣 Other (Specify ≒n+cmbmen+ Lakemon		7 <b>–</b> 05 I	Davideor	nville, MD					
alti	permit. Departn Importe eny inju		21. Signature of Finding Sovice Licensee				neral Home					
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			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.				Approximate Interval Between					
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	/Medical		resulting in death)  a. Due to (or as a consequence of):									
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Ó,	be executed ician and burial-transit	E	resulting in death) Last Due to (or as a consequence of):									
8760,	ate hys	dlcal	d									
9	death certific attending p	a)	IF FEMALE:									
Box	ath ce	an/	23b. Was decedent pregnant in the past 12 months?	3 Ectopic pregnancy		23d. Date of	,					
	at the dea by the at tached fo	SICI	1 Yes 2 No 4 Pregnant at time of death	5 Other (specify)		Month	Day Year					
P.0	that the	Physician/M	9   Olikilowii		T							
ŝ	res tha signed be det	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.			ute to the cause of death?					
orc	w require been si should b	ted	glavcoma / BEINDNESS		1 🗆 Yes	2 No 3	☐ Probably 4 ☐Unknown					
Records,	e law has b je 2 st	Completed by	ScieRoperna		24a. Was an autopsy	24b. Wei	re autopsy findings available in to completion of cause of					
<u> </u>		Con	HYPERCIPIAEMIA		performe	d? dea	th?  Yes 2□ No					
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was can referred to medical examiner?	26. Place of Death	Check onl one							
of \	Physi this c	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ R/Outpa	tient 3 DOA Other: 4 Nursing Hon	ne 5 🗆 Residenc	e 6 Other (	(Specify)					
n	ding P h. After t funera	on:	27. Manner of Death 28a. Date of Injury 1 ►Natural 5 □ Pending (Month, Day Year) 28b. Time		28d. Describe how	injury occurred						
Sio	ittendin death. ctor: Afi / the fur	cati	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No								
Division	or At fter d lirect n by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	at and Number ( State)	or Rural Route Number,					
	urs a											
	Hosp 14 ho Fune Fune	edical	29a. Certifier (Check only and of the best of my knowledge, do (Check only and of the basis of examination and/o	eath occurred at the time, date and place, a investigation, in my opinion, death occurre	and due to the caused at the time, date	se(s) and manner and place, and	er as stated. I due to the cause(s)					
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number								
	7 ≥ 0 0 1 ≤ 1						Month, Day, Year)					
			Remejas	025134		0-14						
			30. Name and address of person who completed cause of death (Item 23a) (Tyr	exerton ST. #101, C	CALE. A	E- 1	1.0 2.022					
			31. Date filed (Month, Day, Year)  32. Registrar's Signature	1, 101, 1	CHUCWA	IEK, M	W. +105+					
	Sta Registr		nct 1 7 2005	1								
			THE A COUL STARLED A AND A									

DHMH 17 Rev 1/2001

ORIGINAL

		1	For State Registrar	State of	of Maryla		artment of F tificate of		d Mental Hy	giene 0 5	3531	5
			1. Decedent's Name (First, Middle	, Last)					2. Date of Dea		3. Time of D	Death
	Physicia /Medic	al -	VERONICA			MOORE			OCTOBE			AA
	Examin	GI	4a. Facility Name (If not institution		ımber)		4b. City, Town, o		eath	4c. County o		
			PRINCE GEORGE H  5. Social Security Number	6. Sex	7. Age (in v	rs. last birthday)	CHEVERLY If Under 1 Year	( If Under 24 F	Irs. 8. Date of Birt	h	GEORGE  9. Birthplace (State or Country)	Foreign
	Funeral Director		202-34-8654	1□M 2X F	58	Yrs.	Months Days	Hours M	in. (Month, Da		Country) PENNSYLVANI	
		-	Usual Residence of Decedent			0: 7					104 (2014)	
	show	_	MD PRINCE	GEORGE		City, Town or Lo	cation				10d. Inside City	
	death with the Maryland ms 23a or 28a-f show r rust be nulliked at	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of W		
:	with t	급	5200 BELGREEN S	ייסדדי ∦אר	13		20746			U.S		
	ns 23	Funeral	11. Marital Status	12. Was Dec	edent Ever in	n U.S.   13.		lispanic Origin?	(Specify Yes or No Jerto Rican, etc.)		- American Indian,	
			1 ☐ Never Married 2 X Marr	ied Armed F	2 <b>X</b> No		fYes, specify Cuba 1 □ Yes 2 No		ierto Hican, etc.)		BLACK	
2	hours after tural', or Ite	d by	3 Widowed 4 Divorced	Year or I	Dates:		1 L 195 2E3 NO	эрвспу.		Specify:		
1215-UU30	"natu	Completed	15. Deceden (Specify only highe	t's Education st grade completed	)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of i	working	16b. Kind of Bus	iness/Industry	
7	filed within 72 Hyglene. Ither than "nat	dmo	Elementary/Secondary (0-12) 12th	College	(1-4or 5+)		TER OPERA			PR	IVATE	
ט ס	ant, and	Be Co	17. Father's Name (First, Middle,	Last)		GOIII 0	TER OF LIN		Name (First, Middle,			
<u>a</u>	s d ta	To B	EARL HICKENBOT	TOM				ANNIE I	REBECCA CI	RAIGWELL		
Maryland	d 2 should th and Men ?7 is marke traumatic	25	19a. Informant's Name/Relations						Rural Route Number			
_	s 1 and 2 f Health item 27 i		BERNARD MOORE/H	USBAND	100			STREET	#303 SUIT			
ore	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from	n State		natory`or other plac	'	Date		City or Town, State	
	permit. Pag Department Important: any injury c once.	1	`4 ☐Donation 5 ☐ Other (S		ML		N CEMETER		-21-2005 JB JENKIN:	CHELTEN		
Ba	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service	Licensee	00				LANDOVER			
	-		23a. Part1. Enter the disease, of shock, or heart failure. Lis	complications that	caused the d						Approximate Interval Betw	reen
	Physician		Immediate Cause (Final disease or condition	only one cause on	gacri line.	f.	Ph	me L			Onset and De	
П	/Medical		resulting in death)	aDue to	o (or as a con	sequence of):	grou		*			-
	Examiner		Sequentially list conditions.	b	ne	ann	m	a				
	pd is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	2 Diffe to	(or as a non	eaduents of):	4 ,	1 1/2	1	£ .		
	and and I-trans	хаш	that initiated events resulting in death) Last	c. Due to	o (or as a con:	securance of):	100	196	47726	0200		
8760,	cate be executed physician and the burial-transit	aiE		1	mak	/mul	Vasa	ulu	Peca	eling		
	fficate g phys as the	edicai		0								
Box	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	ician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pre		∃Ectopic pregnanc	v			of delivery	
m m	death	sicia	in the past 12 months? 1 Yes 2 No		gnant at time		Other (specify)			Mon	th Day Ye	ear
<u>Р</u> О	that the de led by the a detached t	Physi	9 Unknown	4				on in Dard I	230 Did t	obacco usa c. etri	bute to the cause of de	aath?
ŝ	ires tha signed I d be det	by	Part II. Other significant conditi	ons commouting to	death but not	resulting in the t	nderlying cause giv	venin raiti.	1 🗆 '	-	3 ☐ Probably 4 ☐Ur	
oro:	w requir been sl should	eted	- June	7	~				-		/ere autopsy findings a	
Record	has by	Completed	_ Hyper	lens	-				— 24a. Was — autor perfo	osy pr ormed2 de	rior to completion of careath?	use of
a		e Co	OF Was agen referred to median	1				OF Place of	1 ☐ Yes  Death (Check only of	2 No 1	☐ Yes 2☐ No	
Vital	yalcian: The is certificate hadirector, page	O B	25. Was case referred to medical examiner?  1 \sum Yes 2 \sum Vo	Hospital: 1	Inpatient :	2 ER/Outpatie	nt 3 DOA Ott	ner	g Home 5 ☐ Resi		r (Specify)	
Division of	Attending Phyalcian: or death. ector: After this certific by the funeral director,	n: T	27. Manuer of De th	/8.4-	e of Injury onth, Day Yea	28b. Time o		ry at		how injury occurre		
io	l or Attending after death. Director: After in by the funer	Certification:	A COOLGOIN	igation	,,	.,,,		Yes 2 □ No				
<u>i</u>	irecto	rtific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 289. Place	ce of Injury - A	At home, farm, st necify)	reet, factory, office		28f. Location ( City or To		er or Rural Route Numb	oer,
Ω	ospital o hours at uneral D ly filled in								lane and due to the	(-)		
	I 4 II 0	edical	29a. Certifier 1 Certifyi (Check only one) Medical	Examiner: On the	ne best of my basis of exan inner stated.	nination and/or in	n occurred at the ti vestigation, in my d	me, date and pi opinion, death o	lace, and due to the occurred at the time,	date and place, a	nd due to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certific				29c. Licens	se number		29d. Date signed	(Month, Day, Year)	
	r s r o		<b>)</b> / [.	when	re-	3	D	3031	8	10/1	4/05	
01	3)		30. Name and a dress of prsor				Print)	•		17	1	
4			JAMES CATEVENIS				VE CHEVE	RLY, MD	20785	MCO.		
	Sta Regist		31. Date filed (Month, Day, Year OCT 1 8 2	005	Registrar's S	ignature.	8,					

Anthony M. Moton 05-06956 NJM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Marylan		artment of H tificate of I			giene Reg. No.	05	35316
	Physici	an	Decedent's Name (First, Middle, Last)     ANIMALONS		мощ	227		2. Date of Dea Month	Day	Yeer	3. Time of Death
	/Media	cal	ANTHONY  4a, Facility Name (If not institution, give	M.	MOTO		r Location of Death	October	1	2005	2317 M
	Examin	ier		n Road		Marlo H			4c. County of Death Prince George's		
Ī	Funeral Director		5. Social Security Number 6. Sec. 577-90-3764	7. Age (In yrs. 37	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt. (Month, Day 10-19-1	h '	9. Birthp	lace (State or Foreign INGTON, DC
	pu 🔉		Usual Residence of Decedent  10a. State 10b. County	10c Cit	v. Town or Lo	cation					0d. Inside City Limits
	Maryla f ehor	٥	MD PRINCE GE		N HILL	oation				•	1 Yes 2 □ No
	r 28a-	irec	10e. Street and Number	71102		10f. Zip Code			10g. Citizen o	of What Cour	itry?
	ath wit	aiD	7304 OXON HILL RD			20745			U.	S.A.	
036	be filed within 72 hours after deeth with the Maryland ald Hygiene.  Id other then "natural; or items 23a or 28a-f show event, the Medical Examinat must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1  ☐ Yes	1	Vas Decedent of H f Yes, specify Cuba I□Yes 24□No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		lace - Americ lack, White, cify: BI	
9500-61212	72 ho 'natur	Completed	15. Decedent's Edu (Specify only highest grade		(Give	lent's Usual Occup	during most of work	ing	16b. Kind of	Business/Inc	dustry
7	within ane. then	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	ĺ	OO NOT use retired NICATION	n TECHNICIA	AN	PRIVA	TE	
		BeCc	17. Father's Name (First, Middle, Last)		L		18. Mother's Nam				
/lar	2 should be and Mental le marked o reumatic eve	ToB	MERVIN WINSTON				MARY PEA	ARL TYLE	R		
Maryland	s 1 and 2 should if Health and Men item 27 ie marke other treumatic		19a. Informant's Name/Relationship (Ty				and Number or Rur				
_	1 and 2 Health tem 27	18	RENEE A. CARTER-MO	20b. P	lace of Dispos	sition (Name of	MANOR PL	FORESTV		MD 207 n - City or To	
Ē			1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	emetery, cren	natory`or other plac CEMETERY	10-19	2_05	LANDOV		
Baltimore,	permit. Page Depertment ( Important: It eny injury or once.		21. Signature of Funeral Service License				ss of Facility J				
20_	88 2 2 8		X.D.Ma	hall	-		VER ROAD			YLAND	20785
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. Let only or immediate Cause (Final disease or condition resulting in death)		INTVA		g, such as cardiac	or respiratory ari	rest,		Approximate Interval Between Onset and Death
	Examiner			Due to (or as a conseq.	derice or).						
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	uence of):						
	be executed icien end burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):						
8/60	cate be executed physicien end the burial-transit	dicai E	L.								
9	ng physi as the t	Jedic	IE FEMALE.								
O. Box	that the death certificated by the ettending properties detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of di 9 ☐ Unknown	Ideath 3	Ectopic pregnancy Other (specify)		1		Date of delive Month	ry Day Year
2	res that igned by be deta	by Pt	Part II. Other significant conditions cor	stributing to death but not res	ulting in the un	iderlying cause give	en in Part I.	23e. Did to	bacco use co	ntribute to th	e cause of death?
ğ	w require been sig should b	ted t						1 🗆 Y	es 2 No	3 Proba	ably 4 Unknown
of Vital Records,	The lay	Completed			· .			24a. Was a autop perfor TDKYes	med?	o. Were autor prior to con death? 1 2 Yes	osy findings available inpletion of cause of 2 No
N I E	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		2□ DOA Othe	26. Place of Deat				
ō	Physic this sral dii	To :	1 X Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of	28c. Injun	4 Li Hursing Ho	me 5 Resid			Scene
<u></u>	Attending or death.  ector: After by the fune.	atior	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	10:50 f		k? Yes 2,∕⊠No				COLLISION
DIVISION	after death after death Director: ,	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	et, factory, office		28f. Location (S City or Tow	n, State)		
2	ospital or A hours after unerel Dire ly filled in by		29a. Certifier 1 ☐ Cartifying Phys	ROAD							60 HT, MD
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medicai	(Check only 2 Medical Examinations)	sician: To the best of my kno nar: On the basis of examina and manner stated.	wiedge, death tion and/or inv	estigation, in my of	ne, date and place, pinion, death occurr	and due to the d red at the time, o	ause(s) and r late and place	nanner as sta , and due to	ated. the cause(s)
	To the Hospital within 24 hours a To the Funerel I completely filled	Me	29b. Signature and title of certifier			29c. License		2	29d. Date sign	ned (Month, (	Day, Year)
	(1)		▶ anet2			OCM			ctober		
2	10		30. Name and address of person who co	mpleted cause of death (Item	1 23a) (Type, I	Print) III Pe	nn Street	Balti	more,	Maryla	and 21201
	Sta Registr		31. Date filed (Month, Day, Year)  OCT 1 8 2005	32. Registrar's Signa	ture	e					

			1 - For State Registrar	State of Ma	aryland / Depa <i>Cer</i>	artment of H tificate of	lealth and Death		jierze 0 0 5	35317
4	Physici	20	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death
	/Medic		Charles	W		Moore		ÖCT	16 2005	10:32P <sup>™</sup>
	Examir	ier	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Deat	h	4c. County of Deat	h
		Æ.	CIVISTA MEDICAL  5. Social Security Number 6. Secur		(In use inst high day)	LAPLA If Under 1 Year		To 5	CHARLE	
	Funeral Director		·	M 2□F	(In yrs. iast birthday) 86 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day April 8,	Year) Co	hplace (State or Foreign untry)
	e.		Usual Residence of Decedent					April 0,	1919 wes	t Virginia
	nylan show		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Ba-f e	cto	Maryland Prince Ge	orges	Temple Hi	11s				1 XYes 2 No
	vith th	Dire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	untry?
	s 23e	Funeral Director	5601 Nile Place	10.111		20748			USA	
_	ter de	ů,	11. Marital Status 1 □ Never Married 2 ▼ Married	12. Was Decedent E Armed Forces?	1	Vas Decedent of H Yes, specify Cuba	fispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
3	hours after death with the Maryland turel; or Items 23a or 28s-1 show of Exprise must be cattilled at	þ	3 ☐ Widowed 4 ☐ Divorced	1 ∏ Yes 2 □ N If Yes, Give Year or Dates:	° WWII	☐ Yes 21 No	Specify:		Specify: Wh	ite
215-0036	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "naturel", or flems 23a or 28a-1 show event, the Medical Exact for must be ruffled at	Completed	15. Decedent's Edu (Specify only highest grade	cation	16a. Deced	lent's Usual Occup	ation		16b. Kind of Business/	Industry
Z	within 72 ene. than "nat	npie	Elementary/Secondary (0-12)	College (1-4or 5-	Chief	kind of work done of NOT use retired of Plant	auring most of wold) & Operat	ione	Federal Go	
7	Hygier Hygier other th	S	12		011201	or Trant				vernment
and	ntal H	Be	17. Father's Name (First, Middle, Last)		M =			ne (First, Middle, I		
>	should ind Men marke	ဥ	Charles Wa		Moore 10h Mailin	a Addrasa (Ctrast	Minnie			icker
Nar	and 2 s ealth an n 27 le i		Betty Marie Moore						City or Town, State, Z	ip Code)
စ်	- ± a =		20a. Method of Disposition		20b. Place of Dispos	sition (Name of		Hills, M	20c. Location - City or	Fown, State
Ê	Pages nent of int: ff it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ XOther (Specify)	emoval from State Entombmen		natory or other place on Nation	'	per 20,20	05 Suitland,Ma	arvland
gaitimore,	permit. Pages Department of I Important: If It any injury or o		21. Signatura Funeral Service License		22.	Name and Addres	ss of Facility			
מ	88 1 2 8		Flyl 1.1	Jah	Ge 61	orge P. I 60 Oxon F	Kalas Fur Hill Rd	neral Hom	e. P.A. 11, MD 207	45
			23a. Pant. Enter the disease, or compli shock, or heart failure. List only or	cations that caused in cause din	the death. Do not ente	er the mode of dyin	ig, such as cardiad	or respiratory arre	est,	Approximate Interval Between
	Physician		tmmediate Cause (Final disease or condition	Preu	nona					Onset and Death
	/Medical Examiner		resulting in death)		consequence of):		<u> </u>			0,43
	ed A	20	Sequentially list conditions,							
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
	execun and and all-tra	Exai	that initiated events resulting in death) Last	Due to (or as a	consequence of);					
2/20	certificate be executed ding physician and use as the burial-transit	dicail								
Ó	rtifical ng phy as th	0	Les estudes							
X D		an/N	200. Was decedent pregnant	3c. If yes, outcome o		Ectopic pregnancy			23d. Date of deliv	very
- -	e dea the at	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown		Other (specify)			Month	Day Year
Ţ.	w requires that the death been signed by the atter should be detached for u	by Physician/M	Part II. Other significant conditions con	tributing to double but		4		00 01111		
records,	signe d be d		Cerchovascula	n accide		derlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Ö		etec	D [ ]	(. <del>1.</del>						Dably 4 DONKHOWN
Š	G & C	Completed	Diuseres inco	u us				24a. Was ar autops perform	y prior to co	opsy findings available empletion of cause of
		ပို	25. Was case referred to medical					1 ☐ Yes 2	Ø No 1 □ Yes	2 No
>	ysicia s cert direct	0	examiner?	ospital: 1. Inpatien	t 2 ER/Outpatient	3□ po∧ Othe		th Check only one		
5	는 눈물	n:T	27. Manner of Death	28a. Date of Injury (Month, Day		28c. Injury Work	4   Naising H	28d. Describe ho	nce 6 Other (Special winjury occurred	fy)
5	Attending or death. ector: After by the funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident Investigation	(World, Day	rear) Injury		Yes 2 □No			
JIVISION OF	r Atte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur	y - At home, farm, stre (Specify)	et, factory, office		28f. Location (Str. City or Town	reet and Number or Rus	al Route Number,
ב	urs af			1					,	
	To the Hospital or Attending Physician: within 24 hours after death this certific To the Funeral Director: After this certific pompletely filled in by the funeral director,	edical	29a. Certifier 1 Certifying Phys (Check only one)	ier. On the basis of e	examination and/or invi	occurred at the timestigation, in my op	ne, date and place, pinion, death occur	and due to the ca	use(s) and manner as a te and place, and due to	stated.
	o the ithin 2 o the omple	Med	29b. Signature and title of certifier	and manner state	9G.	29c. License			d. Date signed (Month,	
ł	- 3-		MCCCE		mD			25		udy, 18d//
1	-11-1		30. Name and address of person who con	mpleted cause of de	ath (Item 23a) (Type 9	D-53	5592		10/17/05	
_	(6)		ARNEL C. CASTREN		fair in recovering the second	a interest of	#1000 LIST	TVOOD MY	2000	
40	Sta	-	31. Date filed (Month, Day, Year)  OCT 1 9 2005	. Registrar	's Signature	CENTRE.	TANK WAL	MANEY EL	70007	
	Registr	ar	H 111:1 1 39 7003	1 Destroy	14 200					

			1- For 10-19-05 Registrar Amend # 2.&	State of M						ind Me	ental Hy	- (	GUU2	35	5318
d.	۶ م		1. Decedent's Name (First, Middle, Las		5.16.	1 00,	imouto	O, D	Catir		2. Date of De	Reg. No		3. T	ime of Death
	Physici /Medio		Selenge (nmn	*	rjav						Month (	) Da	17 , <sub>Year</sub>		SYOAM
	Examin	_	4a. Fecility Name (If not institution, give	e street and number)	11 /	<i>i</i> .	4b. City, To	wn, or L	ocation of	f Death	,	40	County of Dea		1 4.4
			National Inst	Thutes of	Hal-	m	Be-1	050	AC	rm		<i> </i>	,,,	ome	4
	Funeral		5. Social Security Number 6. S None	ex /.Ag □M 2⊠F	je (in yrs. ia 51	st birthday) Yrs.			Hours	Min.	8. Date of Bit (Month, Da 12 2)	nth ay, Year	9. Bit	ountry)	State or Foreign
	Director		Usual Residence of Decedent		71						12 2	0 33	MOII	golia	1
	/land		10a. State 10b. County		10c. City,	, Town or Lo	cation							10d. Ins	side City Limits
	Man 1 st	to	Mongolia None		U	1aanba	ator							1[	JYes 2∜∑No
	h the	Director	10e Street and Number Bayangol Distric	+ 1/ Vhor			10f. Zip Co	ode				10g. C	itizen of What C	ountry?	
	23a c		Bldg 139 - 69	C 14 KHOI	00		No	ne				Mon	golia		
	ens dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces			Was Deceden	nt of Hisp	panic Orig Mexican,	in? (Spec	ify Yes or No	)-	14. Race - Am- Black, Whi		ian,
98	hours after death with the Maryland turel', or items 23e or 28e-1 show at Expediment sust be notified at		1 Never Married 2 Married	1 □ Yes 2 🔯 If Yes, Give	No		1 □ Yes 2√x		Specify:		,			-	longolia
21215-0036	hours lural',	d by	3 Widowed 4 Divorced	Year or Dates:		10- D-	1 1 - 1	2							
7-	2 5 3	Completed	15. Decedent's Ed (Specify only highest gra			(Give	dent's Usual ( kind of work of DO NOT use of	done du	ion ring most	of working	g	16b. F	Kind of Business	Industry	
12	within ene. then "	μď	Elementary/Secondary (0-12)	College (1-4or	5+)		House		e				Own Hom	Δ	
<u>0</u>	Hyg Hyg She	Be C	17. Father's Name (First, Middle, Last)					1-	8. Mother	's Name	First, Middle	, Maidei			
a		To B	Tsagocin Myagmar	jav					Khov	7100	Ernuuz	Z			
Maryland	d 2 should the and Ment 7 is marked treumstice		19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	ng Address (S	Street and	d Number	r or Rural	Route Numb	er, City	or Town, State,	Zip Code)	
			Soyolmaa Sereedor	j/Daughte	r	Bayan	zurkh	Dist	trict	Bld	g. 23-	-15_1	Ulaanbaa	tor.	Mongol:
Se	- I 9 =		20a. Method of Disposition  1 Burial 2 Tremation 3	Demousl from State	Ce	ace of Dispo metery, cren	sition (Name natory or othe	of erplace)	1	Da	te	20c. L	ocation - City or	Town, St	ate
Ĕ	Pages nent of ent: If it ury or o		'4 □Donation 5 □ Other (Specify		Met	ropoli V	tan Cr	cema-	$  _{1}$	0-18-	-05	Ale:	xandria	, VA.	
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licen	isee		22	. Name and A	Address	of Facility	Mars	ha11's	Fu	neral H	ome	
<u> </u>	2015		& May	hall		42	217 9th	1. S	t. N.	.W. W	ashing	gton	, D.C.		
			23a. Part 1. Enter the disease, or com shock or heart failure. List only	plications that cause one cause on each l	d the death. ne.	Do not ent	er the mode o	of dying,	such as c	ardiac or	respiratory a	rrest,		Appro	ximate al Between
	Physician		Immediate Cause (Final disease or condition	a Drour	nont	a								£1	t and Death
н	/Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):	- 11	1	1	Λ.			11	,0	
	LAGIIIIICI	_	Sequentially list conditions,	b. DISSEN	ninate	801 HS	pengill	W (	and	Hell	novinu	SIr	fection	SIX	weeks
Т	led Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	c. Bone			Tran	2002	int					SIX	months
	al-tra	xar	that initiated events resulting in death) Last	Due to (or as	a conseque	orice or.								21/	פירוטוזיו
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai E		. Chron	ic m	4e 69	enals	Sle	Puke	mio				Vec	rrs
9	ifficati g phy as the	edic		· -											
Вох	eath certific attending p for use as	N/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			Ectopic pregi	nancy					23d. Date of de		
	deat ed for	sicie	in the past 12 months?	4□Pregnant a			Other (speci						Month	Day	Year
P.0	at the de d by the a stached	Physician/Me	9 Unknown								T				
	res tha	by	Part II. Other significant conditions of	ontributing to death b	out not resul	lting in the ur	nderlying caus	se given	in Part I.				use contribute to		
oro	w requir been si should	eted									10	105 2	No 3□P		4 Unknown
Vital Records,	has b	Completed								georgidessignishten	24a. Was auto	psy	prior to	topsy fini completio	dings available n of cause of
E E		Co									1 ☐ Yes	med?	death?	2□ N	0
Viit.	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital: 📜				Other:			Check only o				
of	Phys	: To	1 Yes 2 No	28a. Date of Inju		R/Outpatien 28b. Time of		Injury a	4 U NUIS		e 5 Resi		6 ☐Other (Spe	cify)	
o	ding h. h. After funer	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y Year)	Injury	м 200	Work?	s 2 □ N			10 11 11 11	19 00001100		
Division	i or Attending after death. Director: After d in by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	e 28e. Place of In	ury - At hon	ne, farm, stre	1				f. Location (	Street ar	nd Number or Ri	ural Route	Number,
Ö	after 1 Dire d in b	Certification;	4  Homicide determined	building, et	c. (Specify)						City or To	wn, State	a)		
	To the Hospitei or At within 24 hours after d To the Funerel Direct completely filled in by		29a. Certifier  (Check only 2 Medical Exer	ysicien: To the best	of my know	rledge, death	occurred at t	the time,	date and	place, an	d due to the	cause(s	) and manner as	stated.	- E-7 .
	in 24 in 24 in 6 in 6 in 6	Medical	one)	niner: On the basis of and manner st	ated.	on and/or inv				- OCCUITEC	at the time,	cate an	a piace, and due	to the ca	luse(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	6				icense n 5 7 2 (				29d. Da	te signed (Mont	h, Day, Y	ear)
^	1		NUWVC	12			D.	5720	U D			7	2/76/C	5	
K	(5)		30. Name and address of person who DENISE GONZAI		leath (Item :			c D-	o i •	-	+ h				
	Sta	ite	31. Date filed (Month, Day, Year)	P. Registr	ar's Signatu	ure 🎤	-encer	L DI	Tve	, Be	cneso	ıa,	MD 208	92_	
	Registi	rar	OCT 1 9 200	Blown.	1	goe									

		•	1- State of Maryland / Department	irtment of Health and Me tificate of Death	ental Hygieze	5 35319
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia /Medic	al	Annie Pearl Morrisey  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	October 12,	Year 2005 6:02A <sup>M</sup>
	Examin	er •	Bradford Oaks Nursing Home	Clinton		ce Georges
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
	Director	ļ	238-56-4576 1 M 2 TF 68 Yrs.	Months Day's Flours Min.	Feb. 22, 193	7 NC
	and	1	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc	cation		10d. Inside City Limits
	Many -f she	ţ	Md. P.G. Clinto	on		1 XYes 2 No
	h the	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of	What Country?
	th wit		7520 Surratts Road	20735	United	States
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28e-f show event, it is Medical Examination invalue routified in	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 \( \text{Never Married} \) 2 \( \text{XMarried} \) 1 \( \text{Yes} \) 2 \( \text{XM} \) No	Vas Decedent of Hispanic Origin? (Spec Yes, specify Cuban, Mexican, Puerto R	tican, etc.) Bia	ce - American Indian, ack, White, etc.
21215-0036	urs af	þ	3 Widowed 4 Divorced Year or Dates:	☐ Yes 2 ☑ No Specify:	Speci	Black
2-0	72 ho	ted	(Specify only highest grade completed) (Give I	ent's Usual Occupation kind of work done during most of working	16b. Kind of E	Business/Industry
21	within ene. then	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	OO NOT use retired)		- L -
121	filed w Hygier Ather ti		9 Wa 17. Father's Name (First, Middle, Last)	itress	Priv	
and	should be f nd Mental h marked of	To Be	Bert Cox	Daisey	Goodman	moy
Maryland		F	19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	g Address (Street and Number or Rural	Route Number, City or Town	n, State, Zip Code)
	od 2 lith a 27 Is r tre	1	Barbara Melton/cousin 114	Iroquois Way	20745	
ore	2 -		20a Method of Disposition 20b. Place of Dispos			- City or Town, State
ij	Pages tment of I tent: If it		'4 □ Donation 5 □ Other (Specify) Resurre	,		ton, Md.
Baltimore,	permit. Page Department of Importent: If any injury or once.			Name and Address of Facility HC	odges & Edward Rd., Suitl	
F			23a. Part . Enter the disease, or complications that caused the death. Do not enter strock, or heart failure. List only one cause on each line.		respiratory arrest,	Approximate Interval Between
4	Physician	6 1	Immediate Cause (Final disease or condition Antivissclarufic He	nt Dispure		Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Activiscloratic Heading Due to (or as a consequence of):	C. 1		
		er	if any leading to immediate Due to or as a consequence of :	4 Billing		
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events c.			
Ö,	icate be executed physician and s the burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):			
68760,	ate be hysical the bu	edical	d			
_		/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy			
Вох	law requires that the death certific as been signed by the attending p 2 should be detached for use as i	Physician/M	in the past 12 months?	Ectopic pregnancy Other (specify)	1	ate of delivery onth Day Year
0	t the de by the a	hysi	1 Yes 2 No 9 Unknown			
٥,	es that igned b	by P	Part II. Other significant conditions contributing to death but not resulting in the un	iderlying cause given in Part I.	23e. Did tobacco use con	tribute to the cause of death?
Records,	w require been sig should b				1 ☐ Yes 2 ☐ No	3 ☐ Probably 4 ☑ Unknown
ecc	e law r has be	Completed			autopsy	Were autopsy findings available prior to completion of cause of
<u>=</u>	Th ate pag	Con			performed? 1 ☐ Yes 2X No	death? 1 ☐ Yes 2X No
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death (		
of		. To	1 ☐ Yes 2 ☒ No	1 3 DOA 4 Nursing Home	e 5 Residence 6 Ot 3d. Describe how injury occu	
on	Attending In death.	ıtlon	1X Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	, , , , , , , , , , , , , , , , , , , ,	
Division	I or Attendi after death. Director: A I in by the fu	Certification:	3   Suicide 6   Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	eet, factory, office 28	3f. Location (Street and Num City or Town, State)	ber or Rural Route Number,
	ital or A is after al Direction by	Cert	Juliung, atc. (Specify)		Ony or rown, state)	
	e Hospital 24 hours a e Funeral D	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death (Check only one)  Medical Examiner: On the basis of examination and/or inv and manner stated.			
	To the Hos within 24 h To the Fur completely	Me		29c. License number	29d. Date signe	ed (Month, Day, Year)
			Malin O. Vanan	232500	OCTOR	112, 2005
R	- 16)		30. Name and address of person who completed cause of death (Item 23a) (Type, F	29c. License number 335266  Print) Vrupstn Road Ford	,	, ,
/			William T. TANKEN M 11701 Lis  31. Date filed (Month, Day, Year)  32. Registrar's Signature	viupsta 1600 that	washingth,	mong pand
*	Sta Registi		OCT 1 9 2005	le		
			OPITO COOL MANAGEMENT DE LOS			

State of Maryland / Department of Health and Mental Hygiene 005 35320 Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2:05 PM **Physician** OCTOBER 2005 PAULINE A. MACON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE S LAUREL CHERRY LANE NURSING CENTER | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Oct 25 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6 Sex 5. Social Security Number **Funeral** 1 □ M 21 F 1925 Washington, DC 79 579-26-7390 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or itema 23a or 28a f show any injury or other traumatic event, the Medical Examination must be notified at once. 10a. State 10b. County 1 TYPes 2 □ No Director Washington DC: 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20011 U.S.A. 820 Delafield Place NW Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Black Maryland 21215-0036 þ 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Private Homemaker 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minnie Cornick Jacob Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12604 King Arthur Court Glendale, MD 20709 Shirley Wilson/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State Washington Nat. Ceme Oct. 11,2005 Suitland, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityJohnson and Jenkins Funeral Home 21. Signatur of Funeçal Service Licensee 716 Kennedy Street NW Washington, DC 20011 23a. Part1. Enter the disease, or confplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Dementia Tears **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Box 68760. by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Day Month 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 V Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manper of Death Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 51051 October 13, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ligen Read, Ellicott City, MD 21042 3621 4 ndyes Sala Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 1 9 2005 Registrar

				1- For Amend Item 23a per Dr., 6849, II/OI/O3dhb, Certificate of Death		giene 3.005	35321
				1. Decedent's Name (First, Middle, Last)	2. Date of Dea	ath	3. Time of Death
		Physici /Medic		ADA L. MELLINGER	Sept	30 200	
		Examir	ner	4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	•	4c. County of Dea	
		Francis		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs.	8. Date of Birt	HARF	
		Funeral Director		181-07-1953 10 M 2 KF 93 Yrs. Months Days Hours Min.	SEP 20	(Year)	rthplace (State or Foreign country)
		pu ,		Usual Residence of Decedent			174
		show	5	10a. State 10b. County 10c. City, Town or Location BEL AIR			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
		should be filed within 72 hours after death with the Maryland not Mental Hyglene. I marked other than "natural", or Items 23a or 28a-f show unatic event, the Mudical Exam art must be indiffied at	Funeral Director	MD I+ARFORD BEL AIR  10e. Street and Number 10f. Zip Code		10g Citizen of When C	
		aa or	Ö	112 N. LYNBROOK ROAD 21014		10g. Citizen of What C	ountry?
		er death w Items 23a	Jera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-		erican Indi.
	9	after or Ite	E	1 Never Married 2 Married 1 Yes 2 No	Rican, etc.)		
	21215-0036	ural',	d by	Year or Dates:		Specify: V	IHITE
	15	d within 72 h piene. r than "natu I'lip Medica	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing	16b. Kind of Business	s/Industry
	212	filed withi Hygiene. ther than	mo	Elementary/Secondary (0-12) College (1-4or 5+)		CIGAR FAC	TORY
		be filed tal Hygi of other event, I	Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name	e (First, Middle,	Maiden Sumame)	
	<u>la</u>	ould be Mental arked o	To E	CHARLES E. SNELL DELLA	MAE	BARNHAI	2T
	Maryland	0 0 0 0		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run			
		s 1 and 3 f Health item 27 other tra		SANDRA J. PAULES 112 N. LYNBROOK RD		BEL-AIR M	
	Baltimore,	8 5 = 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)		20c. Location - City o	
0	Ħ					WINDSOR,	
3	Ba	permit. Departriction of the permit of the p		21. Signature of Fundial Service Liebsee 22. Name and Address of Facility BU		LION, PA I	
. 2		eą		23a. Ph.1. Et a. I disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac cock, or hear failure. List only one cause on each line.			Approximate
		Physician		Immediate Cause Final			Interval Between Onset and Death
		/Medical	Н	disease or condition resulting in death)  Due to (or as a consequence of):			2 MONTHS
		Examiner	Ι.	Sequentially list conditions.  Pre renal azotemia			2 wonth
01		ed isit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Alzheimer dementia			_
101		be executed ician and burial-transit	хап	that initiated events resulting in death) Last  Due to (or as a consequence of):			5 years
W	8760	e be ex sician e buria	dical				
0	9	tificate g phys as the	ledic	u.			
5	XO	The law requires that the death certificate be executed to has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of de	livery
-	). B	e dea he att	sicia	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
7	P.0	that the d ed by the detached	Phy	3   Onknown	00 814		
1	ds,	ires ti signe d be c	l by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute t es 2∰No 3□P	o the cause of death?
W	ord	v requii been s should	etec		-		
~	Re	The lavate has	Completed		24a. Was a autop: perfor	sv prior to	utopsy findings available completion of cause of
2	Vital		(D)	25. Was case referred to medical 26. Place of Death	1 Yes	2/X No 1 ☐ Ye	2 □ No
			To B	examiner?		ence 6 □Other (Spe	ación)
	Jo u	ding Phys h. After this funeral di		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		ow injury occurred	icity)
4	vision	Attending r death. ector: After by the fune	atlo	2 Accident investigation M 1 ☐ Yes 2 ☐ No			
0	Ξ	or Att	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S. City or Tow	treet and Number or R n, State)	ural Route Number,
A		Hospital or 24 hours aft Funeral Dir tely filled in		One Codding of Contribution			
		To the Hospital or Attenwithin 24 hours after deati To the Funeral Director: completely filled in by the	Medical	29a. Certifier  (Check only one)  1. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and moner stated. 2. Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the c ed at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
_		To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier 29c. License number	2	9d. Date signed (Mon	th, Day, Year)
		,- >F 0		MIH MD D346-7-			
				30. Name and address of gerson who completed cause of death (Item 23a) (Type, Print)		/ / /	0000
		10		Scoff Huswell 2 North Avenue Bel Ain,	Maryl	and 210.	14
		Sta					- ,
	DL	Registi	004	NOV 0 1 2005 Street & Species			

		•	- State Unpend Item Ragistrar Amend Item	State of M 23a&27 pe 1 per me	aryland / Dep r me G849 G849 Ce	Partment of F 11-18-05 Prtificate of	lealth and Me tas <i>Death</i> 11-21	ental Hygie: -05 ta <b>s</b> eg.	2005	35322
	*	¥	Decedent's Name (First, Middle, Las				2. Date of Death	Day Year	3. Time of Death	
4	Physici /Medic		Daniel L. McClet	lan				October_	24 2005	
	Examin	er	4a. Facility Name (If not institution, give				or Location of Death		4c. County of Dea	th
2	-	All .	470 Mauldin Ave 5. Social Security Number 6. Se		je (In yrs. last birthda	Norther I Year		8. Date of Birth	Cecil	thplace (State or Foreign
9	Funeral Director	- 1		<b>Д</b> М 2□ F	49 Yrs.	Months Days	Hours Min.	(Month, Day, Ye July 29,	ar) $C$	Maryland
	death with the Maryland me 23a or 28a-f ehow count or collified at	_	10a. State 10b. County		10c. City, Town or					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	ecto	MD Cecil  10e. Street and Number		North E	10f. Zip Code		100	Citizen of What Co	
	Sa or	直	470 Mauldin Aven	110		21901			USA	
	death	Jera	11. Marital Status	12. Was Decedent	Ever in U.S. 13		dispanic Origin? (Spec an, Mexican, Puerto R		14. Race - Ame	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other then "natural", or Iteme 23a or 28a-1 ehow other traumatic event, the Medical Examples included an orbiting at	by Funeral Director	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces'  1  Yes 2  If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No		ican, etc.)	Specify: W	rite
5-0	72 ho	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Gi)	edent's Usual Occup e kind of work done	during most of workin	9 16b	. Kind of Business	/Industry
121	hen.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	nstructio	•		0 4.	
d 2	filed v Hygie other i		17. Father's Name (First, Middle, Last)			nsviuexio	18. Mother's Name	(First, Middle, Maid	Construction Surmame)	cuon
an	id be ental ked c	To Be	Donald F. McClel	lan			Mary Dol	cores McD	owe PP	
ary	2 should be filed wi and Mental Hygien is marked other th aumatic event, Ihs	-	19a. Informant's Name/Relationship (7		19b. Ma	ling Address (Street	and Number or Rural			Zip Code)
	and 2 saith a n 27 i		Annette McClella	n/wife	470	Mauldin	Avenue, No	rth East	. Marylar	id 21901
ore	Jes 1 of He if Item or oth		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐	Removal from State		oosition (Name of ematory or other pla	ce) 10-26-	2005	. Location - City or	Town, State
Baltimore,	tment of trant: If It invy or o		4 Donation 5 Other (Specify	)	. West Not	tingham C	emeteru	C	olora, Mo	ryland
Bai	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tree		21. Signatur Fune Service Licen	MI ZIL	<b>—</b>	111 S. Q	ess of Facility R.T. ueen Stree	Foard Fi t, Risin	uneral Ho g Sun, MI	ome, P.A. 21911
			23a. Part1. Enter the disease, or composition shock, or heart failure. List only	olications that cause one cause on each	d the death. Do not e ine.	nter the mode of dyli	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Pneumon						
	Examiner			Due to (or a:	a consequence of):					
	*	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence of):					
	cuted nd transit	Examiner	Cause (Disease or injury that initiated events	c						
90,	The law requires that the death certificate be executed the saben signed by the attending physician and bage 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as	a consequence of);					
68760,	cate b physic the b	edical		d						
	certification of the control of the	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of de	livery
Box.	death cert e attendin d for use i	Physician/M	in the past 12 months?	4 Pregnant a		☐Ectopic pregnanc ☐ Other (specify) _	y 		Month	Day Year
P.0	the de by the a	hys	9 Unknown	9□ Unknown						
	es tha igned be del	by P	Part II. Other significant conditions of	ontributing to death	but not resulting in the	underlying cause giv	ven in Part I.			o the cause of death?
ord	w requir been si should	ted						1 \ Yes	2 □ No 3 □ P	robably 4 Unknown
ec	has by	Completed						24a. Was an autopsy performed	24b. Were a prior to	utopsy findings available completion of cause of
a F								1 PoYes 2□	No 1 Yes	2 □ No
V.		Be c	25. Was case referred to medical examiner?  1 ☑ Yes 2 ☐ No	Hospital:	ient 2 ER/Outpati	Ott	26. Place of Death			
o	Phys er this eral di	<u>1</u>	27. Manner of Death	28a. Date of Inj (Month, D		of 28c. Inju	4   Nursing Hom	Bd. Describe how i	e 6 ⊠Other (Spe	scify) Scene
ion	Attending I ir death. ector; After by the funer	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		a <i>y Year)</i> Injury		Yes 2 No			
Division of Vital Records,	after de after de Directo d in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of it	ijury - At home, farm, tc. (Specify)	street, factory, office	2.	8f. Location (Stree City or Town, S	t and Number or R tate)	ural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	Medical C	29a. Certifier (Check only one)	ysician: To the bes ninar: On the basis and manner s	of examination and/or	ath occurred at the ti investigation, in my o	ime, date and place, a opinion, death occurre	nd due to the caus d at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licens		29d.	Date signed (Mon	th, Dey, Year)
	->-0		1 Thereduce !	1. Viera	an a	OC	ME	Oct	tober, 24	, 2005
	0		30. Name and address of person who	completed cause of	eath (Item 23a) (Typ	e, Print) 111 Po	enn Street			land 21201
			THEN, IE	41449					,	
	Sta Regist		31. Date filed (Month, Day, Year) OCT 2 7 2005	Seems 32. Regis	trar's Signatur	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiefje 05 35323 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Melvin R. McCardell, Sr. ı̈́5, October 1910 2005 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) April 10,1908 Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 217-09-1713 97 Director Yrs. Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location in than "natural", or itams 23a or 28a-f ehow the Medical Examiner must be notified at 10d, Inside City Limits Maryland Cecil 1 ☐ Yes 2X No Conowingo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ā 1086 Liberty Grove Road 21918 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No <u>م</u> Specify: 3 Midowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
Bethlehem Steel Company 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within ; th and Mental Hygiene. 7 Is markad other than "r Elementary/Secondary (0-12) Eleven Years General Superintendent Erection Dept. Sparrows Point, Maryland College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be M. Luther McCardell Cassie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin R. McCardell, Jr. (son) 1066 Liberty Grove Road, Conowingo, Maryland 21918 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Harmony Chapel Cemetery <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 10/18/05 Liberty Grove, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ONGESTIVE Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): inding physiclen and use as the burial-transit Due to (or as a consequence of) Box IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2. No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No Division of Vital 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? of the death.

Director: After 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours el 12 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number

DOSO 96 29b. Signature, and title of certifier 29d. Date signed (Month, Day, Year) Lew Novalloren MA OCTOBER 16, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Nowakowski, M.D., 125 North Main Street, Bel Air, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

8 2005

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Box 68760, P.O. Division of Vital Records, after death. within 24 hours a To tha Funarel [

the Maryland

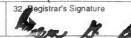
Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 1 4 2005

Mattl



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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygierie For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Paul A. Nicol, Sr. October 0 12 2005 10:40 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2931 Edgewater Drive Edgewater Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
May 7, 1932 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 X M 2 □ F 73 Yrs. Director 579-40-8169 Washington DC Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location or than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits Maryland Anne Arundel Edgewater 1 ☐ Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2931 Edgewater Drive 21037 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 □ No 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1950–51 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Sheet Metal Worker U.S. Government permit. Pages 1 and 2 should be filled v Department of Heelth and Mental Hygies Important: if Itam 27 is marked other ti any injury or other traumatic avent, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Nicol Fannie Hoke ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Nicol/wife 2931 Edgewater Drive Edgewater, Maryland 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore Crematory 10/18/2005 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Cloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Idiopathic Pulmonary Fibrosis **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ettending physicien Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō Month Year 4☐ Pregnant at time of death Day 5 Other (specify) ed by the e 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy his certificate his director, page 1 ☐ Yes 1 ☐ Yes 2 No or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 1 ☐ Yes 2XXVo 2 ER/Outpatient 3 DOA this After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury al Work? Medical Certification: 28d. Describe how injury occurred 1X Natural 5 Pending investigation Injury within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the ! and manner stated 29b. Signature ag 29c. License number 29d. Date signed (Month, Day, Year) D00058297 Oct. 12, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard Young, MD 600 Ridgely Avenue Suite 121 Annapolis, Maryland 21401 31. Date filed (Month, Day, Year) State OCT 1 7 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra 35327 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 7, **Physician** Richard Owen В. 2005 8:00 pp /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 855 Woodmont Road Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1√2 M 2□ F 79 363-26-8028 Director Yrs Jan. 26, 1926 Michigan Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits it is marked other than "natural", or items 23a or 28a-f ebov treumatic event, the Modical Examinal must be notified at MD Director Anne Arundel Annapolis 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 855 Woodmont Road 21401 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Wes 2 ☐ No 1944— If Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 200 Married Completed by 1 ☐ Yes 2√2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 1946 Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Oecedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Foreign Service Officer US Dept. of State 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Richard Benbow Owen, Sr. Evelyn Corev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Marie Owen (wife) 855 Woodmont Rd. Annapolis, MD. 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 27☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oct. 11, 4 Donation Metropolitan Crematory Alexandria, Virginia 21. Signature on uneral Service Licensee 22. Name and Address of Facility Advent Funeral & Cremation Ser. M00982 42 Hudson St., Suite 110 Annapolis, MD. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death (anill Immediate Cause (Final disease or condition resulting in death) Physician cignted /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it airy, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed ettending physicien end for use as the burial-transit Exami resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Year 5 ☐ Other (specify) Day been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1/ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate hes tirector, page 2 s autopsy performed 1 Yes 20 No Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury safter death. 1 ☐ Yes 2 ☐ No filled in by the f 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after of To the Funeral Direct completely filled in by Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29b. Signature and title of certifier 20051301 30. Name and address of person ited cause of death (Item 23a) (Type, Print) PJ #300 Annapotis, MO 21481 900 Perra at Knopt 31. Date filed (Month, Day, Year) State OCT 1 3 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 15 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Delia Ridge O'Donnell October 11, 10:20 pM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Bladensburg

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 4206 54th Street Prince George's 8. Date of Birth (Month, Day, Year) Feb. 10, 1917 9. Birthplace (State or Foreign Country) Massachusetts 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🕅 F Yrs. 88 579-05-8234 **Director** Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ral, or items 23s or 28s-f show Examiner next be notified at 1 ☑ Yes 2 ☐ No Prince George's Bladensburg Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4206 54th Street 20710 USA filed within 72 hours after death Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ 3 ₩ Widowed 4 Divorced Specify: White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary U.S. Government la marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Ia marked oth eny lipiry or other traumatic event 2008. Peter Ridge Mary Cady 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4206 54th Street, Bladensburg, Maryland 20710 Carol D. McFarlane - POA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Highland Cemetery Oct 20, 2005 Norwood, MA \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home. P.A. Claude to Darch Lanning 4739 Baltimore Ave., Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Severe chronic brain syndrome /Medical Due to (or as a consequence of): Examiner Carcinoma of the colon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Atrial fibrillation Due to (or as a consequence of): physician a Division of Vital Records. P.O. Box 68760. Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy this certificate 1 Yes 2⊠ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 70 1 ☐ Yes 2X No 3 DOA After thi 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending 1 ☐ Yes 2 🛣 No investigation Director: 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D08520 10/12/2005 nou 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7525 Greenway Ctr Dr., T6, Greenbelt, MD 20770 Iomas J. Hernandez 31. Date filed (Month, Day, Year) 82. Registrar's Signature State OCT 1 8 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Charles D. October 13,2005 9:30pm M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5480 Wisconsin Ave Chevy Chase Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug 30, 1927 Birthplace (State or Foreign Country) 1 → M 2 □ F Yrs. Director 432-36-2268 78 Memphis, TN Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits itam 27 is markad other than "natural", or Itams 23a or 28a-f show other traumatic evant, the Medical Examinar must be notified at Director 1 X Yes 2 No MD Montgomery Chevy Chase 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 5480 Wisconsin Ave, #622 20815 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Arms 2 □ No If Yes, Give Year or Dates:1943-1947 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White by 1 Yes 2 No 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) is 1 and 2 should be filed within if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electronic Technician Electronics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Deane Plummer Ethel Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Plummer / Wife 5480 Wisconsin Ave #622, Chevy Chase, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of Hi
Important: If ital
any infuryor oth 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 10-17-05 \* 4 ☐ Donation 5 ☐ Other (Specify) Suitland, MD 22. Name and Address of Facility
Joseph Gawler's Sons, INC Willes 5130 Wisconsin Ave, N.W. Washington DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Renal Cell Carcinoma disease or condition resulting in death) 5 Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and the burial-transit Cause (Liscase or inju-that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? ō Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown þ signed to Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. by Prostate Cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has autopsy performed? 1 Yes 2 No To the Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death Check only one) examiner? Other: 2 1 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) anthony I. D0023592 October 14,2005 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anthony I. Corvelli M.D. 5530 Wisconsin Ave Chevy Chase, MD 20815 31. Date filed (Month, Day, Year) 32 Registrar's Signature OCT 18 2005 Registrar

Physician /Medical Examiner Funeral		ent's Name	First Mide				•		110 01	Death	,		Reg. No				30
/Medical Examiner			1 /		T	1					v	2. Date of Month	Death Day	v	Year	3. Time	of Death
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I	Physici		1. Decedent's Name (First, Middle, Last)	PRITCHE	-#-	2. Date of Death Month	Day Year	3. Time of Death  /8:00 A M
	/Medic Examin		4a. Facility Name (If not Institution, give street and number		4b. City, Town, or Location of Death  PATIMORE	-	4c. County of Death	10.00#
	Funeral Director			ge (In yrs last birthday) Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y	9. Birth	place (State or Foreign ntry) YLAND
	Maryland	tor	10a. State 10b. County	10c. City, Town or Lo	cation TMORE			10d. Inside City Limits
	th with the 23s or 28s ast be not	al Director	10e. Street and Number 2724 E. OLIVER J	7.	10f. Zip Code 2/2/3	10g	. Citizen of What Cou	ntry? S.A.
5-0036	72 hours after death with the Maryland natural', or itams 23a or 28a-f show diest Examiraer must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Deceden Amed Forces  1 Yes, 2 If Yes, Give Year or Dates:	No	Was Decedent of Hispanic Origin? (Sp. f Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify:	can Indian, etc. LACK
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	1 and 2 sho Health and am 27 is m thar traum	(	19a. Informant's Name/Relationship (Type, Print)  LORIA C. BLOWE (SIS)  20a. Method of Disposition	Tex) 581	ng Address (Street and Number or Rum Sition (Name of natory or other place)	to BA	City or Town, State, Zip  TO MD 2  c. Location - City or To	1239
Baltimore,	permit. Pages Department of I Important: If it any injury or o once.		1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 14 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service, Licensee	VOSHELL 22	CEMETERY 10.10	1611N C.	ATTIMORE,	MARYLAND WERME HM
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of Vital	Physici rthis cerral direc	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 ☐ Inpat  27. Manner of Death 28a. Date of Inj		t 3X DOA Other: 4 Nursing Ho	me (Check only one) me (Check only one) 28d. Describe how	ce 6  ☐ Other (Specif	y)
Division	To the Hospital or Attanding within 24 hours after death.  To the Funaral Director: After completely filled in by the funer	Certification:	27. Manner of Death    Natural   5   Pending   investigation   3   Suicide   4   Homicide   Homicide   28a. Date of Inj. (Month, D.)  28a. Date of Inj. (Month, D.)  28a. Place of Inj. (Month, D.)	jury - At home, farm, str. (Specify)	28c. Injury at Work?  M 1 Yes 2 No eet, factory, office	28f. Location <i>(Stree City</i> or Town, S	et and Number or Rure State)	ul Route Number,
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			30. Name and address of person who completed cause of	5/2	Print) Balt mora	md	2/2	24
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State of Maryland / Department of Health and Mental Hygiege, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 6,2005 **Physician** WILLIAM PICKETT 2340PM /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George County Hospital Prince George Cheverly If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.
Min. March 29, 1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Director 251-14-5833 South Carolina 85 Usual Residence of Decedent withIn 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show orient: if item 27 is marked other than "natural", or items 23s or 28s-1 sho Injury or other traumatic evant, the Medical Examinar must be notified at Funeral Director Prince George 1x Yes 2 □ No Largo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 600 Largo Road 20774 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ∰ Yes 2 □ No If Yes, Give WWII Year or Dates: WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Store Worker 12 Federal Gov't. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any lighty or other traumatic event size. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Homer Pickett Sara Latta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillie Pickett/Wife 5733 29th Ave. #302 Hyattsville, MD 20782
Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 10/18/2005 Suitland, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service, Licensee 22. Name and Address of Facility Cedar Hill Funeral Home, Inc. May Hedgman MO 1374 4111 Pennsylvania Ave. Suitland, MD 20746 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part1. Enter the disease Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Physician MYOCAR DIAL ACUTE /Medical **Examiner** Artenul Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical as the attending *IF FEMALE* esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ó 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) 9□ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by page 2 should be 1 □ Yes 2 □ No 3 Probably 4 Withhown been 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performed? 1 ☐ Yes 2 GHO 1 Yes 2 HO funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred After or Attending Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation efter death 2 Accident the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 58182 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L. DONALD REDIGE 130.5 Hand Hanover PK.WY. # A. Greenbelt, Md. 31. Date filed (Month, Day, Year) State OCT 1 8 2005 Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 35334 For State Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month October 17, 2:39 P M Betty Port 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 7290 Southern Maryland Boulevard Owings Calvert | Months | Days | Hours | Min. | Aug. 23, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖎 Director 220-38-4681 63 1942 |Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ont: If item 27 is marked other then "neturel", or Items 23a or 28e-1 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits if Health and Mental Hygiene. Item 27 Is marked other then "neturel", or Items 23a or 28e-1 show other treumetic event, the Medical Examinationals Legislation Director Maryland Prince George's 1 Yes 2 No Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6924 Furness Ave. 20745 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2000No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ŽÍXNo Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 12th Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Earl Dean, Sr. Gussie Mary Smith P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda A. Higgins/Per.Rep. 7290 Southern Maryland Blvd. Owings, Md. 20736 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages:
Department of F
Importent: If ite
any injury or ot
once. 1 X Burial ACremation 3 □Removal from State Resurrection Cemetery 10/21/2005 Clinton, Maryland ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Sprince Lie nseg George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 acl. 41 23a. Party. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician adenocorrunoma disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequential list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d, Date of delivery 3 □Ectopic pregnancy Live birth 2 Fetal death for in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.0. detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed 2 No 3 Probably 4 Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🔀 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b Time of 28d. Describe how injury occurred 1XXNatural 5 Pending after death. Director: Af investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a Medical 29a. Certifier XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Doo 27189 M 30. Name and address of person who completed the of death (Item 23a) (Type, Print)

ZAHIR YOUSAF 2417 Solomon Island Rd. 31. Date filed (Month, Day, Year) . Registrar's Signature OCT 1 9 2005 Registrar

State of Maryland / Department of Health and Mental Hygie () 5 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Shirley Η. Pollard 11, October | 2005 3:26A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges Il Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 212 F Director 411-64-0194 65 Yrs. Nov.17, 1939 VΆ Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location ehow 10d. Inside City Limits 7 is marked othsr then "natural", or items 23s or 28s-f shov traumstic event, the Medical Execution must be modified at Director Md. PG Camp Springs 1√2 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 8601 Temple Hills Rd. #80 20748 Funeral United States permit. Pages 1 and 2 should be filed within 72 hours after deal Depertment of Health and Mental Hygiene Important: If item 27 is marked other then "natural" or 11-2069. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No þ Specify. 3 XWidowed 4 ☐ Divorced Specify: Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Urologist Howard Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Samuel W. Hairston Frances Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5345 Essex Court 2231 Danielle Thomas-Pollard/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 10/17/05 1 □ Burial 2 X Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Crematory Riverdale, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** pulmonny embolism disease or condition resulting in death) Unknowy /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Ona to (or as a consequence of) Examiner anding physician and use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 □Ectopic pregnancy Year 4☐Pregnant at time of death Day P.O. | 5 Other (specify) been signed by the should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Jonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Ad6 ornal 1 Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA After th funeral 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No the 2 Accident within 24 hours efter deal To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) filled in by 28f Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 — Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 — Medical Examilier. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 43446 Fre 10-13.05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROINTAN FARAHIFAR M.D 9801 Georgia Am Snit 3-41 Silverspring MD 20902 31. Date filed (Month, Day, Year) 🕰. Registrar's Signature State OCT 1 9 2005 Registrar

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4.	Physici		Harry W. Reech	hel							Month Oct.	10. 2	Yeer 2005	
	/Medic Examir		4a. Facility Name (If not institution		r)		4b. City,	Town, or	Location of	of Death	ac.		y of Death	11:35 p <sup>m</sup>
	=xaiiii	•	1437 Baltimore	a/Annamolic	Dl. rd				rnol			1		Arundel
	Funeral		5. Social Security Number	6. Sex 7. A		last birthday)			If Under		8. Date of Birth			place (State or Foreign
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	irylar show		10a. State 10b. County MD Anne	Amm de 1	10c. Ci	ty, Town or Lo								10d. Inside City Limits
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21215-0036	within 72 hours after death with the Maryland ene. then 'neturel', or Items 23a or 28e-f show the Madical Exertirer must be notified at	Completed	15. Deceden (Specify only highes			(Give	dent's Usua kind of wor	rk done d	urina mosi	t of worki	ng	16b. Kind of E	Business/Ir	ndustry
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2	tygie tygie her t		5 17. Father's Name (First, Middle,	( act)										verment
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Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Interportent: If Item 27 is marked other then "neturel", or Items 23e or 28e-f show eny Injury or other treumetic event, The Medical Examination must be notified at once.		19a. Informant's Name/Relations Bonnie Seidelma		_		ng Address Madie				Route Number,			
e)	1 and dealt		20a. Method of Disposition	- Daugiteei		Place of Dispo			,		Saint L			
Ö	it of it of		1 X Burial 2 ☐ Cremation	3 Removal from Stat	Gla	emetery, crei	natory or of	ther place	2,7   (	oct."	14.	20c. Location		
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Bal	Depermine Depermine Important Inc.		21. Signature of Faneral Service	Licensee		R	name and	d Address	Sons	, P.A	A. Seve	rna Pa	rk Fi	uneral Home
	TO = 0 0		Joen Ch	James		49	15 GOV	7. Ri	tch16	e Hwy	y. Seve	rna Pa	rk, N	D 21146
×			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	ed the deat line.	h. Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory arre	st,		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or a				1			4			111111111111111111111111111111111111111
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ita Ita	ysicien: The is certificate ha director, page	Be	25. Was case referred to medical examiner?						26. Place	of Death	(Check only one	-		
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<u>≅</u>	r Attencter death	Certification:	3 Suicide 6 Could n 4 Homicide determi	ined 286. Place of Ir	jury - At ho	ome, farm, str	eet, factory,	office		2	8f. Location (Stre		er or Rura	l Route Number,
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	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Medical		and manner s	ated.					. 0000118	s at the time, dat	e and place,	ariu uue (C	ind cause(s)
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	Sta	te ar	31. Date filed (Month, Day, Year)		rar's Signa	ture			/			)		

State of Maryland / Department of Health and Mental Hygiepen 05 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** EUGENE A. RICHARDSON OCTOBER 2005 1:20 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE HARFORD 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 220-03-3679 1 XM 2 ☐ F Director 83 Yrs. Jan 26, 1922 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. fnside City Limits Director Maryland Harford 1XYes 2 □ No Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 565 Penninton Avenue 21078 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1942–45 1 ☐ Yes 2 X No Specify: þ Specify: Black 3 XWidowed 4 ☐ Divorced "naturel" Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry rthan Elementary/Secondary (0-12) College (1-4or 5+) Ballistics Research US Government Item 27 is marked other other traumetic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Richardson Amy Crouch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Regina A. Richardson / daughter 809 Cayuga Ave., N.E., Palm BAy, Florida 32905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages:
Department of H
Important: If Ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State R.A. Ferris & Co. ' 4 ☐Donation 5 ☐ Other (Specify) 10/24/05 West Chester, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lisa Scott Funeral Home, P.A.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

25c. Lewis Street, Havre de Grace, shock, or heart failure. List only one cause on each line. MD 21078 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Penile /Medical Due to (or as a consequence of): Examiner Chromic nal failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): certificate be executed Exam sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): 68760 Physician/Medical the use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery atter for u 3 Ectopic pregnancy Month 4☐Pregnant at time of death Day Year 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Division of Vital 2X No 1 ☐ Yes 2 ☐ No After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Cthen: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 SER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0047813 actorbandon October 17 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 11VA (SASHAR KARAKASH 520 Upper Chesapeake Dr. Suite zu BelAir MD 21014 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State OCT 1 2 2005 Registrar

State of Maryland / Department of Health and Mental Hygie $\mathfrak{De}()$ 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** OCTOBER 12, REBECCA L. RAHR 2005 /Medical 11:15 AM 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CHESTER RIVER MANOR CHESTERTOWN KENT Months Days Hours Min. AUGUST 8, 1938 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 M 2 XF 67 214-42-7988 Yrs. Director MD Usual Residence of Decedent with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Modical Examiner must be notified at MD QUEEN ANNE'S CHESTERTOWN Funeral Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 121 SNYDER LANE 21620 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) COOK HOSPITALITY permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event ADRs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ROBERT CANNON NOLA WILLIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANNE JACOB/DAUGHTER P.O. BOX 157, WORTON, MD 21678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State \* 4 □ Donation 5 □ Other (Specify) SUDLERSVILLE CEMETERY OCT. 15,2005 SUDLERSVILLE, MD 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
130 SPEER ROAD, CHESTERTOWN, MD 21620 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Prevnonin mediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death Month Day 5 Other (specify) Ö the detached 9 Unknown δ Records, P. signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEVENE DELL PAIN & VENTER MET WHEN THE PARTY OF THE PA 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an has autopsy performed? certificate Division of Vital 1 ☐ Yes 2 - No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1. Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

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completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) J0060301 who completed cause of th (Item 23a) (Type, Print) Name and address of per RD SPOS CHESTON Then, ND MICHAEL Emmen 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Donald Richardson October 17, 2005 2:25 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3200 N. Leisure World Blvd #910 Montgomery Silver Spring If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) Georgia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**XX**M 2 ☐ F 253-26-8190 84 Director July 11, Usual Residence of Decedent death with the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f show the Medical Examinational be notified at 1 ☐ Yes 2XXXXIO Maryland Montgomery Silver Spring Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3200 N. Leisure World Blvd #910 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Q/ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1XXYes 2 No 1942filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White ģ 63 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Lt. Colonel Military 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill iment of Health and Mental H tant: If item 27 Is marked other. Louis A. Richardson Carolyn Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3200 N. Leisure World Blvd. #910 Silver Spring, MD 20906 Helen R. Richardson - Wife or other 20b. Place of Disposition (Name of cometery, crematory or other place) December 19, 2005 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department or Important: If any injury or once. Arlington Nat. Cemetery Arlington, Virginia \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Solvice Licenses 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC MELANOMA MONTHS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown DEED VENOUS THROMBOSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy perform 1 ☐ Yes 2 ☐ No XXXVo Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2XXNo Other: 4 Nursing Home 5XXResidence 6 Other (Specify) 2 filled in by the funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 1 XNatural or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Sig. e and title of certifier 2005 010560194 10 6825 16th St., dress of person who completed cause of death (Item 23a) (Type, Print) Jarrod Holmes, M.D. Walter Reed Army Medical Center, Washington, DC 20307 31. Date filed (Month, Day, Year) State OCT 1 9 2005 Registrar

State of Maryland / Department of Health and Mental Hygiere 0 05 35340 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year Physician BRUCE RALSTON October 16, <u>6:56</u> P <sup>™</sup> 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cemetery Circle 3507 Knoxville Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 ☐ F 176-60-9169 26 16,1979 Pennsylvania Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show rthan "natural", or Itema 23a or 28a-f shov the Medical Examinar must be notified at Maryland Frederick Knoxville 1 Tyes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3507 Cemetery Circle 21758 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Co. 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fi Scott Kevin Ralston Sherri Lilley Lyn 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott Kevin Ralston / Father 2400 Millcreek Rd. / Austinburg, Ohio 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Eagleville Cemetery 10/24/2005 Austinburg, Ohio 23a. Part. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of leart failure. List only one cause on each line.

Immediate dause (Final disease or condition resulting in death) 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1100 N. Maple Ave. / Brunswick MD Physician /Medical Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner led by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: Self inflicted 1 Natural 1 🗌 Yes 2 Accident investigation 3 Suicide Homicide 6 Could not be determined At home, farm, street, factory, office home 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kohi 31. Date filed (Month, Day, Year) State OCT 1 9 2005

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 05 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month. Physician Christina Mary October 3:10 AM /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Oakland Rehabilitation Center Egireti Patland Nursing and 8. Date of Birth (Month, Dey, Year)
Jan. 1, 1909 If Under 24 Hrs. If Under 1 Year 9. Birthplece (Stete or Foreign County) Maryland 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Days Months 96 1 ☐ M 2 🖫 F 216-76-7477 Director Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f shorte Medical Examiner must be notified at MD. Garrett Lonaconing 1 ☐ Yes XXNo Director 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number Pine Swamp Road 21539 United States 230 Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S Armed Forces? Race - American Indian, Black, White, etc. 11. Merital Status 1 ☐ Yes 2 X No If Yes, Give Yeer or Dates: 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXIII Specify: Be Completed by 3 XXVidowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Housework Homemaker 12 other permit. Peges 1 and 2 should be filed Department of Health and Mental Hyg Important: if item 27 is marked other any injury or other traumatic event, I 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mortimore Broadwater Ida Bittinger 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Dewitt/ daughter in law 115 Seemont Drive, Kingwood, West Virginia 26537 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20e. Melhod of Disposition 10/28/ 2005 cemetery, cremetory or other plece) 1 Surial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donalion 5 ☐ Other (Specify) Swanton Maryland Broadwater Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Boal Funeral Home a 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** inanition Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner sexile onse years or Attending Physician: The lew requires that the death certificate be executed use as the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) resulting in deeth) Last cate has been signed by the attanding pege 2 should be detached for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 KNo 3 Probably 4 Unknown Chronic schizophrenia, Be Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? To the Hospital or Attending Physician: The lew within 24 hours eftar death. To the Funeral Director: Atter this certificate has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medical 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28c. Injury at Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Seleturel 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) complately filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical end menner steted. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) POBOX 247 Accident MD21520 Naumann 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State OCT 2 6 2005 Registrar

DHMH 16 Rev 6/95

ORIGINAL

			1 - For State of Maryland / Department or Certificate of Maryland / Department / Departme	f Health and Mo of Death	ental Hygie Rag		35342
	Dhysisi		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		DODEDE COLOMON			6 2005	1125 <sup>M</sup>
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			Chester River Hospital Center Chest	ertown		Kent	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye Annual A		8. Date of 8irth (Month, Day, Y	ear) 9. 8 irthp	place (State or Foreign
	Director		21) 30 3020		(Month, Day, Y 08/10/1	1939 M	1D
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			1	Od. Inside City Limits
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	tha 28a	Lec	2 10e. Street and Number 10f. Zip Cod	le	10g	. Citizen of What Cour	
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	death ms 2	Jera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent	of Hispanic Origin? (Spec Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - Americ	
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	1 and 2 Health tem 27 l		Bonnie Solomon-daughter 221 Dutche			√n , MD 21 c. Location - City or To	
و	Se de la		1 Burial 2 O'Cremation 3 Removal from State cemetery, crematory or other				WII, State
altimore,	it. Partmen		'4 ☑ Denation 5 ☐ Other (Specify) Capitol Crema 21. Signature of Funeral Service Licens 9 22. Name and Ad				
Ba	permit. Page Department of Important: If any injury or once.		Service	ddress of FacilitKenn = 821 W. S	St. Anna	apolis, M	ral ID 21401
г			23a. Fanh. Enter the disease, or complications that caused the death. Do not enter the mode of a shock, or heart failure. List only one cause on each line.	dying, such as cardiac or	respiratory arrest		Approximate Interval 8etween Onset and Death
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bro	v require been sig should t	ted	CORONARY ANTERY 215EASE		1 🗆 Yes	2 No 3 Prob	abiy 4 📆 Onknown
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<u> </u>		Completed			performed		2□ No
Vital Records,	nysician: Th	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
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Division of	death. ctor: A y the tu	Ical	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office		8f Location (Stree	t and Number or Rura	I Route Number
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	ne Ho n 24 l ne Fu	edical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in mone) and manner stated.	y opinion, death occurred	d at the time, date	and place, and due to	the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Ž		ense number	29d.	Date signed (Month, L	Day, Year)
			1 Wall Camp D	32353		0/18/05	
	Ocatis		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			1	
			130 LOUE POINT Rd STEVENSVILLE.	MD 216	66, D	ANIEL K	ONICK MD
	Sta Registr		50T 0 1 2005 W/A / // //600405 //				

			1 - For State Registrar	State of	Maryland	d / Depa <i>Cei</i>	artment of H	lealth a Death	and Mo		gieze Reg. No.	05	35343
	Physici	an	1. Decedent's Name (First, Middle, L							2. Date of De. Month	ath Day	Year	3. Time of Death
	/Media		June Walthea Sto						1- 1	Octobe		2005	5:04 A. M
	Examir	er	4a. Facility Name (If not institution, g		iber)		4b. City, Town, or Silve					ounty of Dea ntgome	
	Funenci		Holy Cross Hosp: 5. Social Security Number 6.		7. Age (In yrs. Ia	ast birthday)	If Under 1 Year	If Under		8. Date of Birl			
	Funeral Director		578-54-5742	1□M 2⊠F	65	Yrs.	Months Days	Hours	Min.	8. Date of Birt (Month, Da 8/18/2	y, Year) 10	Gar	thplace (State or Foreign ountry)  Tudiana
	pu ,		Usual Residence of Decedent		100 City	, Town or Lo							
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	death ms 23	Funeral	11. Marital Status	12. Was Dece	dent Ever in U.S	3. 13.	Was Decedent of Hi f Yes, specify Cuba		gin? (Spec	cify Yes or No		. Race - Am	erican Indian,
36	be filed within 72 hours after death with the Maryland tal Hygiene. Ind other than "natural", or Itams 23a or 28a-1 show event, it a McJicol Fracili vernissi be rectified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	If Yes, Giv	2 <b>∑</b> No		f Yes, specify Cuba 1 □ Yes 🏽 X No	n, Mexicar Specify:		lican, etc.)		Black, Whi pecify: E	te, etc. Black
8	hour	ed b	15. Decedent's	Year or Da	1065:	16a. Dece	dent's Usual Occupa	ation			16b Kind	of Business	/Industry
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ž	d 2 should be fi th and Mental H 7 ia marked ot traumatic evar	70	Aaron McCombs  19a. Informant's Name/Relationship	(Type Print)		10h Mailir	ng Address (Street a					Tourn State	Zin Codel
Ma	d2: thar 7 is		Alicia Stokes/Da				Crestwick						
ē,	- T & 5		20a. Method of Disposition			ace of Dispo	sition (Name of natory or other plac	1 (0	Da	ate	20c. Loca	tion - City or	Town, State
Ë	Pages nent of I int: If its		1 Burial 2 □ Cremation 3 14 □ Donation 5 □ Other (Spec		nale		Mem. Cem.	۔ ا	0/8/0	5	Suitl	and, N	Md.
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lic	ensee V. O	au	22	Name and Address H.S.Wash	s of Facilit	n & S	ons Co	.,Inc	• naton	D.C. 20019
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that ca	used the death.							ngcom	Approximate Interval Between
4	Pnysician	0 0	Immediate Cause (Final disease or condition	1500116	oticania								Onset and Death 36 hours
	/Medical Examiner		resulting in death)	Due to (	r as a consequ	ence of):							
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9	e as t	Med	IF FEMALE:										
Вох	The law requires that the death certific te has been signed by the attending p tage 2 should be detached for use as in	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	1☐Live bi	come of pregnan rth 2 ☐ Fetal o ant at time of dea	death 3	Ectopic pregnancy				230	<ul> <li>Date of de Month</li> </ul>	livery Day Year
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Records,	w requires been sign should be									1 🗆 Y	∕es 2 <b>⊠</b> i	No 3□P	robably 4 Dunknown
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		Com								perfo	rmed? 2 No	death? 1 ☐ Yes	
/ita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			24			(Check only o			
of Vital	Phys this al dir	5	1 ☐ Yes 2 No 27. Manner of Death	1 (25) Ir		R/Outpatier 28b. Time of				e 5 🗌 Resid			ocify)
on	Attanding r death. sctor: After by the funer	tlon	1 Natural 5 Pending 2 Accident investigati		f Injury 7, Day Year)	Injury	Work	k? Yes 2⊟		34. D6301106 1	iow injury c	ccurred	
Division		Certification:	3 Suicide 6 Could not determine	be 28e. Place	of Injury - At hon g, etc. (Specify)	ne, farm, str	eet, factory, office		2	Bf. Location (S City or Tow		Number or R	ural Route Number,
Q	iospital or hours afte uneral Dii ily filled in												
	Hos 4 h Fun ely	edical	29a. Certifier (Check only one)  1 Certifying F 2 Medical Exi	Physician: To the aminer: On the ba and mann	sis of examination	rledge, death on and/or in	n occurred at the tim vestigation, in my op	ne, date an pinion, dea	d place, ar th occurre	nd due to the o	date and pl	nd manner as ace, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	1111	1 10	<b>*</b>	29c. License		00-			3	h, Day, Year)
0	(A)		1 Chendless	· LWil	in Ma	<u>د</u>	D 00	0619	13/		10	115/1	05
K	(5)		30. Name and address of person who	ILSON, N	10 - 15	00 FC	REST 60	EN	SIL	VER S	PRIN	u, m	0 20910
	Sta Registi		31. Date filed (Month, Day, Year)  OCT 1 8 20	05 Z. Re	egistrar's Signatu								
	riegisti	Tall	UC1 1 0 20	US PERCE	HE LAN	MILE	W.						

			For State Registrar	State of M	laryland / De <i>C</i>	partment e <i>rtificate</i>	of Health and <i>of Death</i>	d Mental Hygi	<b>20</b> 05	35344
		*	1. Decedent's Name (First, Midd	fle, Last)				2. Date of Death Month		3. Time of Death
	Physic /Medi		Esther V.	Smith				OCT	16 2005	0905 AM
	Examir	ner	4a. Facility Name (If not institution				wn, or Location of De		4c. County of Death	
			ST. AGNES  5. Social Security Number	HOSPITAL 6. Sex 7. A	ge (In yrs. last birthda		LTIMOR Year If Under 24 H		non	
ų.	<ul><li>Funeral</li><li>Director</li></ul>	ń.	218-03-5792	1 □ M 2 1 F	85 Yrs.		Days Hours M			place (State or Foreign ntry) yland
	and		Usual Residence of Decedent  10a. State 10b. Count	y	10c. City, Town or	Location				10d. Inside City Limits
	Maryl f sho	jo	Md. Balt	imore	Catonsv	1110				1 ☐ Yes 2 No
	288	Director	10e. Street and Number	SIIIOI C	Catorisv.	10f. Zip C	ode	10	g. Citizen of What Cou	ntry?
	h with	D	815 Winters	Lane Apt 407	7		21228		USA	
	deat deat	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13	3. Was Deceder	nt of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - Ameri	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Examination to the required of the contractions.	þ	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☑ Divorce	rried 1 ☐ Yes 2 🖸	No ·	1 ☐ Yes 25		eno Aican, etc.)	Black, White,	_
5-0	72 ho	Completed	15. Decede	nt's Education est grade completed)	16a. Dec	cedent's Usual	Occupation	working 1	6b. Kind of Business/In	dustry
7	within ene. than "	npie	Elementary/Secondary (0-12)	College (1-4or	5+)		done during most of v retired)	voi king		
2	led w		/yrs			Homema			Home	
and and	i 2 should be filed within h and Mental Hygiene. I is marked other than " raumatic event, the Mes	Be	17. Father's Name (First, Middle					lame (First, Middle, M	,	
2	d Mer nark	2	Christian 19a. Informant's Name/Relation	Staines	405-44-			retta Fis		
Ma	d 2 si th an t7 is r traur		James Smith		11				City or Town, State, Zip	Code)
	permit. Pages 1 and 2 Department of Health Important: If item 27 i any njury or other tra ance.		20a. Method of Disposition	/ SON	20b. Place of Dis	Coving	of	Columbia, M	0. 21044 0c. Location - City or To	own. State
υÖ	Pages nent of P ant: If ite ary or of		1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		1	rematory or other				
Baltimore,	permit. Pag Department Important: I any njury c	li i	21. Signature of Funeral Service		Loudon I	Park Cen 22. Name and	etery Address of acility H	arry H.Wit	altimore,Mo zke's Famil	VFH Too
B	permit. Deperte Importe any nji		Whohe P	mato	100045	4112 01	a columbia	a Pike EII:	cott,City,	Md. 21043
1				or complications that cause it only one cause on each l	d the death. Do not e ine.	nter the mode	of dying, such as card	iac or respiratory arres	st,	Approximate Interval Between
4.	Physician		Immediate Cause (Final disease or condition resulting in death)	a. ACUT	E REN,	AL FA	LURE		-	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):				7	
24		ē	Sequentially list conditions,	t. DEH	consequence of):	ION				DAYS
	rted	듣	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<b>3</b> 250 10 101 25	consequence on.					
	al-tra	Examin	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
68760,	ificate be executed g physician and is the burial-transit	edicai		d						
89	CD of	edi								
Вох	eath certifi attending for use as	N/UE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic preg	22004		23d. Date of delive	ery
В	at the dea by the att	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown		Other (spec			Month	Day Year
<u>~</u>	that the		Part II. Other significant condit	ions contribution to death i	out not resulting in the	undorhing onu	an amon in Part I	220 Did toba	and the contribute to the	an annual of dansh?
of Vital Records,	Se Go	d by	Takii. Ottor olgimioani ooliait	contributing to death t	out not resulting in the	underlying cau	se given in Pan I.		cco use contribute to the	ably 4 (Junknown
Ö	w requir been s should	ompleted						24a. Was an	24h More auto	psy findings available
Re	The la cate has page 2	Ę						autopsy	prior to con death?	npletion of cause of
		ပိ	25. Was case referred to medical	1		-	00 Diago of D	-	No 1 ☐ Yes	2.2 No
5	ysicie is cert direct	0 8	examiner? 1 Yes 2 No	Hospital:	ent 2 ☐ ER/Outpati	ent 3□ DOA	0	eath Check only one	ce 6 □Other (Specifi	.1
ō	ng Phy ter thi	뒽	27. Manner of Death	28a. Date of Inju	ıry 28b. Time		Injury at Work?	28d. Describe how		/)
Ö	Attending death, ctor: After y the funer	atio	1, □Natural 5 □ Pendi 2 □ Accident invest	ng (Month, Da igation	l <i>y Year)</i> Injury	M	1 ☐ Yes 2 ☐ No			
Division	I or Atten after deat Director: I in by the	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 289 Place of In	jury - At home, farm, stc. (Specify)	street, factory, o	ffice	28f. Location (Stre City or Town,	et and Number or Rura State)	l Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification pletely filled in by the funeral director.		29a. Certifier 1/2 Certifyi	ng Physician: To the best	of my knowledge, de	ath occurred at	he time, date and nia	ce, and due to the cau	sa(s) and manner as et	ated
	he Ho in 24 t he Fui pletely	ledicai	(Check only 2 Medical one)	Examiner: On the basis of and manner st	if examination and/or	investigation, in	my opinion, death oc	curred at the time, date	e and place, and due to	the cause(s)
	To the I within 2: To the I complet	Ž	29b. Signature and title of certific	er er er er er er er er er er er er er e			cense number		Date signed (Month,	
)				M	D	AS	24385	28 (	OCT, 16	,2005
16	2		30. Name and address of person						•	
		4	ABDUL SAID		ATON A	VE.	BALTIMO	RE 21	229	
	Sta Registr		31. Date filed (Month, Day, Year	9 2005 32. Posisti	rar's Signature	ha.v.				

SMI TH, ESTHER

State of Maryland / Department of Health and Mental Hygieze 0.535345 1 = For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October **Physician** 2005 2:30 PM Wilhelmina I. Sands /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 10526 Georgia Ave. Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Day), Year | Nov. 17, 1922 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F Months Yrs. 82 Florida Director 267-28-7931 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f ehow ust be notified at 1 ☐Yes 2 ☐ No Director Silver Spring Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 10526 Georgia Ave. 20902 or items 23a United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status traumatic event, the Modical Examiner of ifiled within 72 hours after de l'Hygiene. other then "naturel", or item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 2 Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene importent: if item 27 ie marked other the any injury or other traumatic event, III. DICE. 12th School Adm. Aide Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Thomas Brown Ida Hancock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herbert F. Sands - Son 10526 Georgia Ave., Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory Softer 1 20a Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State \* 4 ☐Donation 5 ☐ Other (Specify) Memorial Park Cem. 10/22/2005 Miami, Florida 21. Sign Jure of Funeral Service Licens 22. Name and Address of Facility Stewart Funeral Home euso 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shocl, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final disease or condition Physician Uterine Cancer resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs Cises or it july Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical the attending | for use as as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 👿 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 24 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospitel or Attending Phyeician: within 24 hours after death.

To the Funerel Director: After this certificat 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 【XNo 1 Inpatient P 3 DOA 2 ER/Outpatient After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D29142 October 18, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10301 Georgia Ave., #205 Silver Spring, MD Charles Boice, M.D. 31. Date filed (Month, Day, Year) State OCT 1 9 2005 Registrar

AEM Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#1, perMF, C850 12/1/05 TT

1- State Amend Item 1&Unpend Item 23a&2/ per me C849 11-15-05 tas 2 0 5

Registrar Certificate of Death # 05-07095 Benjamin Taylor 1. Decedent's Name (First, Middle, Last)

Ben jamin K. Taylor, 2 Date of Death 3. Time of Death Dav **Physician** TAYLOR October 0 19,2005 5:25 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7718 Allendale Drive Landover
If Under 1 Year | If Under 24 Hrs. Prince George's 7. Age (In yrs. last birthday) Funeral 5. Social Security Number 8. Date of Birth (Month, Day, Year) 1942 9. Birthplace (State or Foreign Days Hours Months 1⊠M 2□F Yrs Director 63 577-58-7373 SEPTEMBER 6 VTRGTNTA Usual Residence of Decedent Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 7 is marked other then "natural", or items 23e or 28a-f ehow treumatic event, the Medical Examinar must be notified at 1X Yes 2 No Director PRINCE GEORGE'S LANDOVER MD the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20785 7718 ALLENDALE DRIVE death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Army If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 and 2 should be filed within 72 hours after v Health and Mental Hygiene. 8m 27 Is marked other then "netural", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK à 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BAKER 11th PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM A. TAYLOR MAGGIE L. JENKINS ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BENJAMIN K. TAYLOR JR/SON Itam 27 I 3869 W. PEACHTREE LN. PORTSMOUTH, VIRGINIA 23703 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of Hi
Important: If Iter
eny injury or oth 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State MARYLAND VETERAN'S 10/28/05 CHELTENHAM, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND traci 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Atherosclerotic Cardiovascular Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical ettending for use as IF FEMALE: If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. the à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records. sign ed 1 | Yes 2 | No 3 | Probably 4 V Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ∠Yes 2 □ No 24a. Was an autopsy performed? page 2 s certificate 1 Yes 2 □ No Hospitel or Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Scene Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient မှ M☐Yes 2☐No 3 DOA this After this funeral c 28c. Injury at Work? 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funsrel Di completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) OCME October 20, 2005 enu BH 30c Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 KOLLAK 31. Date filed (Month, Day, Year) . Registrar's Signature. State

DHMH 17 Rev 1/2001

Registrar

QCT 2 6 2005

•			For State Registrar	State of M	laryland / Depa Ce	artment of Health an		gieze ()	5 35347
0	Physicia		Decedent's Name (First, Middle,  Jesse Turner	Last)			2. Date of Dea Month		Year 13:15 A M
	/Medic Examin		4a. Facility Name (If not institution, Atlantic Genera		)	4b. City, Town, or Location of D		4c. County	
	Funeral Director		5. Social Security Number 214-32-2185		ge (In yrs. last birthday) 75 Yrs.	If Under 1 Year If Under 24	Hrs. 8. Date of Birt (Month, Day 12 / 12 /	h /, Year)	Birthplace (State or Foreign Country)     MD
	Maryland f show	tor	Usual Residence of Decedent  10a. State  10b. County  MD  Worce	ester	10c. City, Town or Lo	cation			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	or 28a-	Director	10e. Street and Number		Deriin	10f. Zip Code		10g. Citizen of V	What Country?
36	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mantla Hygiene. Department of Health and Mantla Hygiene. Integrate: If tiern 27 is marked other than "natural", or liems 23a or 28a-f show important: If tiern 27 is marked other than "natural", or liems 23a or 28a-f show any injury or other traumatic swant. I'm Medical Evanting must be notified at once.	Funerai	10425 Friendsh  11. Marital Status  1 □ Never Married 2 ★ Marrie	12. Was Decedent Armed Forces	No	21811  Was Decedent of Hispanic Origin f Yes, specify Cuban, Mexican, P  1 ☐ Yes 2 ☑ No Specify:	? (Specify Yes or No- cuerto Rican, etc.)	US 14. Rac Blac Specify	e - American Indian, ck, White, etc.
Maryland 21215-0036	ithin 72 hours 19. 18n "natural", 18 Madical Era	Completed by	3 Widowed 4 Divorced  15. Decedent (Specify only highest Elementary/Secondary (0-12)	Year or Dates: s Education	16a. Dece (Give life.	dent's Usual Occupation kind of work done during most of DO NOT use retired)		16b. Kind of Bu	usiness/Industry
and 21	d be filed w antal Hygier ted othar th c svant, In	Be	8 17. Father's Name (First, Middle, L  Jesse Mumford	•			perator Name (First, Middle, ma J. Tru	Maiden Sumam	truction
laryl	2 shoul and Me Is mark aumati	2	19a. Informant's Name/Relationsh		19b. Mailir	ng Address (Street and Number o	r Rural Route Numbe	r, City or Town,	
ē, N	tam 27		Erma Turner  20a. Method of Disposition		20b. Place of Dispo	5 Friendship R	d., Berlin		1811 City or Town, State
altimore,	permit. Pages Department of Important: If i any injury or once.		1 XBurial 2 Cremation 4 Donation 5 Other (Sp 21. Signature of Fund al Service L	ecify)	Evergree	n Cemetery 10  Name and Address of Facility			MD uneral Home
m m	Dermi Depa Impo any ir		23a. Fart1. Enter the disease, or	bulas	_	108 William St.,	Berlin, M	AD 2181	
3006	icate be executed /Medical Examiner s the burial-transit	dical Examiner	shock, orhean failure/List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause List of the sequential of the sequential of the sequential of the sequents of the sequents resulting in death) Last	a	line.	trusher pu			Interval Between Onset and Death  20   5 907/5
12-12- 19,3 10-19 - 2 P.O. Box 68	es that the death certifical igned by the attending phy be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Dat	ne of delivery nth Day Year
5.8: V	quires that n signed build be deta	by	Part II. Other significant condition	ns contributing to death	but not resulting in the u	nderlying cause given in Part I.			ribute to the cause of death? 3 ☐ Probably 4 ☑Unknown
35 \$5 1 Refor	sician: The law requires certificate has Leen sign rector, page 2 should be	Completed					24a. Was a autop. perfor	med?	Were autopsy findings available prior to completion of cause of death?  Yes 2 No
& & S	siclan: certific irector,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	ient 2 ☐ ER/Outpatier	Other	Death (Check only or		
-33-	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	-	27. Manner of Death  1 Natural 5 Pending 2 Accident investige	28a. Date of Inj (Month, Da	ury 28b. Time of	1 3 DOA 4 Nursir	ng Home 5 Resid 28d. Describe h		
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Diractor: Attercompletely filled in by the fune	Certification	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	288. Place of In	njury - At home, farm, str tc. <i>(Specify)</i>	eet, factory, office	28f. Location (S City or Tow	treet and Numb n, State)	er or Rural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dirac completely filled in by	edicai	29a. Certifier 1' Certifying (Check only one)	Physician: To the best xaminer: On the basis and manners	of examination and/or in	occurred at the time, date and p restigation, in my opinion, death o	lace, and due to the o occurred at the time, o	ause(s) and ma late and place, a	nner as stated. and due to the cause(s)
	To t with To t	Σ	29b. Signature and title of certifier	SIC	Del	29c. License number	2	_	(Month, Day, Year)
C.H	.5		30. Name and address of person v	(in) DO 9	122 HCD17H	DAY NO BER	CIN MD		
9	Sta Registr		31. Date filed (Month, Day, Year)  OCT 1	2005 32 legist	rar's Signature	rede			

			For State Registrar		Sta	ite of M	<b>1</b> arylar	nd / Dep <i>Ce</i>	artmen	t of H	ealth a	and M	lental Hy	gienne	A 100	5 3	353	48
			1. Decedent's Name	First, Middle,	Last)			_					2. Date of De	eath			3. Time of	Death
	Physici /Medic		Wayne Mo	rgan Ta	bor, S	Sr.							Month Octob	er 18	3, 20	Year 005	6:25	A M
1	Examin		4a. Facility Name (If	•	•	and number	7)		4b. City,	Town, or	Location of	of Death		4c.	County	of Death		
				al Hosp							1and					Legan	<u> </u>	
	Funeral Director		5. Social Security No. 214–46–31. Usual Residence of	15	6. Sex 1 <b>X</b> M 2		.ge (In yrs.	last birthday, Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bi (Month, Di Sept •	14,19	946	9. Birthpl Count Nest	Virgi	nia .nia
	land ow		10a. State	10b. County			10c. Cit	ty, Town or L	ocation							10	d. Inside Ci	ity Limits
	Man a-f sh	to	MD	Garre	tt		Fı	riends	ville							i	1 🗌 Yes	2 <b>X</b> No
	th the	lrec	10e. Street and Nun						10f. Zip	Code				10g. Citiz	zen of W	hat Count	ry?	
	23a unit b	Funeral Director	279 Friend	dsville	-Addis	son Ro	oad		215	531				USA	L.			
	tems	rue	11. Marital Status		Arr	s Decedent ned Forces	? 100	.s. 13.	Was Deced If Yes, spec	ent of Hi	spanic Orig	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	D- 1		- America		
36	hours after death with the Maryland tural', or Items 23a or 28a-f show al Examinat court be couldled at	by Fi	1 Never Marrie 3 Widowed		od 15	Yes 2 ☐ es, Give ar or Dates:	1140	รัล	1 ☐ Yes 2	X No	Specify:				Specify:	Whi	+0	
9	2 hou			15. Decedent's	Education		ATECI		dent's Usua	I Occupa	ıtion			16b. Kir	nd of Bus	iness/Ind		
Maryland 21215-0036	be filed within 72 hours after death with the Marylan stal Hygiene. od other than "natural", or liems 23a or 28a-f show event, the Madical Extension on at the posities of	Completed	(Speci	ify only highest		oleted) llege (1-4or	5+)	(Give	kind of wor DO NOT us	k done d	lurina mosi	t of worki	ng				,	
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pu	be file tal Hy d oth	Be (	17. Father's Name (	First, Middle, L.	ast)								(First, Middle	, Maiden	<i>Suma</i> me	)		
yla	should be and Mental marked our	ဥ	James E.										Woods					
Mar	12 sh h and 7 Is m traum		19a. Informant's Na			nt)		1:					/ Route Numb					
	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		Mary Jane 20a. Method of Disp	_	Wife		20b. F	2/9 F:			L-Add:		Rd., E			lle,		21531
nor	ages int of t; If it		1 🔀 Burial 2 🛭	☐Cremation :		ıl from State	_   0	emetery, cre	matory`or ot	her place		_	21,200			•		
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any njury or other once.		* 4 ☐ Donation  21. Signature of Fur				GL						wman Fi					
ä	Department Department		De la	sul	Run	roer							ville,				536	
i.			23a. Part1. Enter the shock, or hear	e disease, or o	omplications	s that cause se on each l	ed the deat	h. Do not en	ter the mode	of dying	, such as	cardiac c	r respiratory a	rrest,			Approximate Interval Bety	ween
III.	Enysician	10	Immediate Cause (I	Final	a	1	une		Can							13	Onset and [	Death UWM
	/Medical Examiner	. 4	resulting in death)	- 1	C	Due to (or as			,								. W	
		<u>.</u>	Sequentially list con	nditions,	b	Due to (or as		mor	na								5 d 5 d	045
	ted	nine	Sequentially list con if any, leading to im Cause (Disease or i	mediate dyling injury	4	100	-	ion cli	0.0		10	100	char	)			5 d	ayo
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8760,	cate be executed physician and the burial-transit	dical E			d													
9	ntifical ng ph as th		IS SSMANS															
Вох	death certifis e attending p id for use as	an/h	IF FEMALE: 23b. Was decedent in the past 12 i			es, outcome Live birth			Ectopic pre	gnancy				2		of deliver	•	
0.	ne death the atte	Physiclan/Me	1 Yes 2 9 Unknown			Pregnant a Unknown	at time of d		Other (spe						Montl	n L	Day Y	'ear
<u>q</u>	= > 0	Phy	Part II. Dther signifi	cant condition	s contributio	ng to death i	hut not res	ulting in the u	nderlying on	USO CIVO	n in Part I		23e Did t	obacco us	en contrib	ute to the	cause of di	oath?
ds,	Se un e	d by	Turrii. Daner sigiimi	out outland	o continuati	ig to double	Dut Hot 163	uning in the u	ilderlying ca	usa giva	mm raiti.			Yes 2		☐ Proba		Inknown
Sor	w require been sig should b	ete											24a. Was					
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tal		a	25. Was case referr	ed to medical							oc Place	of Dogsth	1 Yes	2€ No	1 [	Yes 2	No	
		OB	examiner? 1 ☐ Yes 2 ☑ 1		Hospital	l: Na Inpati	ient 2 🗆	ER/Outpatier	nt 3 🗆 DO	Othe			Check onl one 5 Residue		Other	(Specify)	3.8	-
οr	கை மே ம	T : u	27. Manner of Death		28a.	Date of Inju	ury	28b. Time o		c. Injury	at		8d. Describe					
Ö	Attending or death. ector: After by the fune	atlo	1 Natural 2 Accident	5 Pending investiga		(11101111)	., ,	,	М		es 2 🗆 N	10						
Division		Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin		Place of In building, e	ijury - At ho tc. <i>(Specif</i> )	ome, farm, sti y)	eet, factory,	office		2	8f. Location (8 City or Tox		Number	or Rural i	Route Numb	ber,
	pital o		Con Continu	4	Dh			1.1.										
	To the Hospital or Attendin, within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Medical	29a. Certifier (Check only one)	1 Certifying 2 Medical E	xaminer: Or	To the best the basis of d manner st	of examina	wledge, deat tion and/or in	n occurred a vestigation,	t the time in my opi	e, date and inion, deat	f place, a h occurre	nd due to the ed at the time,	cause(s) a date and p	and mann place, an	ner as stat d due to t	ed. ne cause(s)	
	To the within 2 To the complet	Me	29b. Signature and I	title of certifier		QQ			29c.	License	number			29d. Date	signed (	Month, Da	ay, Year)	-
				Ales	lua				-	عما (	475	2		Octo	ber	18	, 200	5
1	+VA	1	30. Name and addre	ss person w				1 23a) (Type,	Print)							-	70	
Y			Ataa ,	Ahmac	I.W. J.			ent A	venu	e	Cu	-mb	erland	Ma	xylo	und	2150	2
	Sta Registr	-	31. Date filed (Mont	CT 24	2005	32. Regist	iais signa	B. A	1300 B									

			1 - For State Registrar		State of M	arylan		artment ( <i>rtificate</i>			Mental Hy	ygien Reg. N	UUU	35349
	Physici	an	1. Decedent's Name								2. Date of D Month	eath D	ay Yea	
	/Medic Examir	al	Joseph R 4a. Facility Name (#					4b. City, To	wn, or Lo	ocation of Dea	th OCT	16	c. County of De	23 50 M
	Funeral Director			sity Sp	eciality	7 Hos	sjpta. last birthday) Yrs.	If Under 1 Y	ear I	ore If Under 24 Hrs Hours Min		ieth	Baltim	
	land bw		Usual Residence of I	Decedent 10b. County		10c. Cit	y, Town or Lo	cation		1				10d. Inside City Limits
	e Mary	ctor	Md	Charles		Вз	ryanto	own						1∭Yes 2□No
	th with the 23a or 28 Ist be no	Funeral Director	10e. Street and Num 5910 Ro		Pl.			10f. Zip Co	2061	7		10g. C	itizen of What USA	Country?
980	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: if Item 27 te marked other than "neturel", or Items 23a or 28e-f show any injury or other treumatic event, if e Madical Examiner wast by multired at once.	þ	11. Marital Status  1 □ Never Marrie 3 □ Widowed 4		12. Was Decedent Armed Forces? 1 ☑Yes 2 ☐ If Yes, Give Year or Dates:	,		Was Decedent f Yes, specify 1 ☐ Yes 21又		anic Origin? (S Mexican, Puel Specify:	Specify Yes or N to Rican, etc.)	0-	14. Race - Ar Black, Wi Specify: B	
Maryland 21215-0036	vithin 72 hc ne. han "netul	Completed	(Specification (Speci	15. Decedent's Edi fy only highest grad dary (0-12)	ucation de com <i>pleted)</i> College (1-4or	5+)	(Give life. L		lone dur etired)	ing most of wo			Kind of Busines	
Q 25	filed v Hygie other t		1.7. Father's Name (F	First, Middle, Last)			Expl	osive		erato	<b>r</b> me (First, Middle			Government
/lan	uld be Mental Irked c	To Be	George		oson					_	ce Bel			
Mary	d 2 sho		19a. Informant's Nar Catheri			e.					ural Route Numb			
	of Heali Item 2 other		20a. Method of Dispo	osition		20b. P	lace of Dispo	sition (Name of	of		Date		Location - City of	
Baltimore,	Page tment c tent: ff jury or		`4 □Donation 5	5 ☐ Other (Specify,		St	. Mar	y's Cl	hur	ch 10	)/21/05	Bry	antowr	n, Md
Ba	permil Depar Impor any in		21. Signature	7 2	1	191	Ac		'une	ral H	ome, Ad		sco,Md	20608
TE.	Priysician /Medical	i y	23a. Part1. Enter the shock, or heart Immediate Cause (F disease or condition resulting in death)	inal	a	ne.	liac (	arthe mode of			c or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Examiner		On a second all sellent areas		Due to (or as			tic h	eain	it dis	ease			5 425
	ed sit	niner	Sequentially list condificant, leading to immorause. Enter Undert Cause (Disease or in	ving	Due to (or as	a consequ	uence of):							·
68760,	tificate be executed g physicien and as the burial-transit	ai Examiner	that initiated events resulting in death) La		Due to (or as	a consequ	uence of):							
		Medicai	IF FEMALE:		a							-		
P.O. Box	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/M	in the past 12 m 1 Yes 2 9 Unknown	nonths?	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal	death 3	Ectopic pregn Other (specif					23d. Date of d Month	elivery Day Year
	w requires that s been signed b should be deta	ed by Pr	Part II. Other signific		ntributing to death b				e given i	n Part I.				to the cause of death? Probably 4 대에nknown
al Records,	sicien: The law r certificate has be irector, page 2 sh	Completed by	Diabet	s, pe	mipheral	reisi	cular	diseas	e	Dement	perfe		prior to death?	autopsy findings available completion of cause of
Vital	Physicien: r this certificatal director, I	o Be	25. Was case referre examiner? 1 ☐ Yes 2 ☐ ✓	L.	Hospital: 1 IIInpatie		ER/Outpatient	10004			ath (Check only		. 50	
Division of	Jing After fune	$\vdash$	27. Manner of Death  1 Natural  2 Accident	5 Pending investigation	28a. Date of Inju (Month, Da	-	28b. Time of Injury	28c.	Injury at Work?	4 □ Nursing F	lome 5 Resi			ecify)
Divis	E Dig	Certification:	3 🗍 Suicide 4 🔲 Homicide	6 Could not be determined	28e. Place of Inj building, et	c. (Specity	r) 				City or To	wn, Stat	(e)	Rural Route Number,
	To the Hospitel or within 24 hours after To the Funerel Discompletely filled in	edical	29a. Certifier 1 (Check only 2 one)	I ☑ Certifying Phy 2☐ Medicel Exemi	sician: To the best ner: On the basis o and manner st	r examınat	wledge, death ion and/or inv	occurred at the estigation, in r	ne time, my opini	date and place on, death occu	e, and due to the arred at the time,	cause(s date an	s) and manner and place, and du	as stated. ue to the cause(s)
	To the within To the compli	Me	29b. Signature and ti	itle of certifier	/			29c. Lic	cense nu	ımber		29d. Da	ate signed (Mor	nth, Day, Year)
-		-	20.41			E571			30	494			10-18-0	5
(	183		30. Name and address					,	3 5	- Be	Himare	e m	N 2 1530	3
**	Sta Registr		31. Date filed (Month	Day, Year)	32. Registr			2.00			-			

Jaseph Thompson

State of Maryland / Department of Health and Mental Hygiene 35350 For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** HOMAS Ctober /Medical et and number) 4a. Facility Name (If not institution, give sta 4b. Çity, Town, or Location of Death 4c. County of Death **Examiner** Charles tughesville )enise If Under Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funeral 8. Date of Birth (Month, Day, Months Year! 1 ■ M 208 F Days Hours Min -38-095 Yrs. Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits item 27 la marked other then "natural", or items 23e or 28a-f show other treumatic event, the Modical Examitar must be mortified at 1 Pres 2 □ No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes 2 No BIAC Specify: Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MANAG 1.2 Kennedu 17. Father's Name (First, Middle, Last) . Mother's Name (First, Middle, Maiden Surname) Be TON informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 la m. any injury or other: 19b. Mailing Address (Street and Number 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State MARYIAND \* 4 ☐ Donation 5 ☐ Other (Specify) Surrection 21. Signature of Funeral Serv Adams Funeral Home YA. MD 20608 TOUASCO. 23a. P. rt1. Enter the disease er compleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory sets shock, or leart failure. List only ne cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Find Physician META STATIC BREAST YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** BONE HETASTASIS YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit YEARS METASTAS IS MARKOW Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe GOUT 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown Completed been 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has b irector, page 2 sl Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼No 2 1 Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 Yes 2 No 2 Accident investigation Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after of Funeral Direct 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 0 mp, mp 05 D43162 10/13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7831 BELLE POINT DR. GREENBELT, MD , MD MELVIN GASKINS 32. Pygistrar's Signature 31. Date filed (Month, Day, Year) State OCT 1 8 2005 Registrar

	Mikaela 05-7117 AKG	Tł	nornwell Please Type or Print in Blac Unpend item#23a,27, perME, G849,1 State of Maryland/I	k Indelible Ink. Ensure Al Department of Health and M Certificate of Death		are Legible. epe () () 5 g. No.	35351
	Physic		1. Decedent's Name (First, Middle, Last) Mikaela Thornwell		2. Date of Death Month October	Day 20, 2005	3. Time of Death 5:45 P M
	/Medi Examir		4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital	4b. City, Town, or Location of Death Clinton		4c. County of Dea	ath
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 M F 5	thday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day Feb. 1	9. Bi 2000	rthplace (State or Foreign Country) Maryland
	e Maryland la-f show	ctor	MD Prince Georges Upper	norLocation Marlboro			10d. fnside City Limits 1 X Yes 2 □ No
	with th	i Dire	10e. Street and Number 9909 Pitman Ave.	10f. Zip Code 20772	10	g. Citizen of What C USA	Country?
36	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Heatth and Mental Hygiene. Inportant: if item 27 is marked other than "naturel", or iteme 23a or 28a-f show any injury or other traumatic event, I a Medical Evanth or most te notified at ance.	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  11 Never Married 2 Married  12 Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give	13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	acify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
Baltimore, Maryland 21215-0036	thin 72 hour e. an *naturei'	Be Completed b	3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired)	ng 10	6b. Kind of Business	
and 21	I be filed winted Hygien and other the event, the		1 17. Father's Name (First, Middle, Last) Michael Thornwell	Student 18. Mother's Name	(First, Middle, Ma	aiden Sumame)	ry School
aryl	should ind Mei marki umatic	ပ္		Kimber I  Mailing Address (Street and Number or Rura			Zip Code)
Σ	and 2 salth a n 27 is		Michael Thornwell/Father 99			-	
timore	Pages 1 tment of He tant: If iten jury or oth		1X Burial 2 □ Cremation 3 □ Removal from State Resur	v. cramatony or other place)		oc. Location - City or Clinton	
Ball	permit Depar impor any in		21. Signatury of Fulleral Sept@ Licensee	22. Name and Address of Facility  Adams Funeral Ho	ome, Aqı	uasco, M	d 20608
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comications that caused the death. Do not shock, or hear failure. List on one cuse on each line. If mediate Cause (final disease or condition resulting in death)  a. Lymphocytic My (Due to (or as a consequence of the content of	ocarditis	r respiratory arres	t,	Approximate Interval Between Onset and Death
68760,	executed an and irial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of the consequen				
.O. Box	ne death certif the attending thed for use a	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)	No	23d. Date of de Month	olivery Day Year
Ω.	w requires that the bean signed by should be detact	Ď	Part If. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did toba	1	o the cause of death?
Vital Records,		Completed			24a. Was an autopsy performe	d? prior to death?	utopsy findings available completion of cause of s 2 \( \text{No} \)
Vita	Physician: The this certiticate ral director, pag	o Be	25. Was case referred to medical examiner? 1 № Yes 2 □ No Hospital: 1 □ Innatient 200€ R/Out	26. Place of Death			
n of		H	27. Manner of Death 28a. Date of Injury 28b. T	patient 3 DOA 4 Indising Hor	ne 5 Residence 8d. Describe how	e 6 □Other (Spe injury occurred	ecify)
Division of	or Attending after death. Director: Atter in by the tune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	8f. Location (Stree City or Town, S	et and Number or R State)	ural Route Number,
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, 2X Medical Exeminer: On the basis of examination and and manner-stated.	death occurred at the time, date and place, a	nd due to the caused at the time, date	se(s) and manner as and place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	W	29b. Signature and title of gentitie	29c. License number OCME	00	Date signed (Mont tober 21,	2005
	DB		30. Name and address of person who completed wise if death (Item 23a) (	Typa, Print) IIII Penn Street	Baltim	ore, Mary	land 212 1
	Sta	te	31. Date filed (Month, Day, Year) 32. P. strar's Signature OCT 2, 6, 2005	land a			

	1 _ State	- 7			2000	0000
		ast)	Certificate of		Death	3. Time of Death
	Elizabeth Kirby	Wells		10/10		2:30 P M
Physician   The physician   Th						
		Say 7 Ane (In ure		If Under 24 Hrs.   9 Date of		
		1 DM 250E	Months Days	Hours Min. (Month,	Day, Year) 3/1908 Sou	Country)
		10c Cit	v. Town or Location			
led at						1X Yes 2 No
Irect		Georges Lar			10g. Citizen of What	Country?
	9885 Greenbelt R	oad APt. # 112	20706		USA	
nue		Armed Forces?	S. 13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Specify Yes or van, Mexican, Puerto Rican, etc.)	No- 14. Race - A Black, W	
by F		If Yes, Give	1 ☐ Yes 2 <b>X</b> No	Specify:	Specify:	White
eted			16a. Decedent's Usual Occu	pation during most of working		
mple		College (1-4or 5+)		•	1	
ပိ	17. Father's Name (First, Middle, La		Park Naturall	T		
0 B	Thomas Worth Ki	rby		Lillie Grant		
	<del>-</del>					
	1 ☐ Burial 2 🖾 Cremation 3	Chemovar noin State				
		Tital				
£ 8	1					
	shock, or heart failure. List or	ly one cause on each line.		ng, such as cardiac or respirator	y arrest,	Approximate Interval Between Onset and Death
	disease or condition	_ a				
		Due to for as a conseq	Free T	Tailers		10 years
Je	if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):			
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an/M	23b. Was decedent pregnant			e <b>y</b>		
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A Ph		contributing to death but not res	ulting in the underlying cause g	ven in Part I. 23e. D	id tobacco use contribute	e to the cause of death?
d be	Renal	Atri lul-	<u> </u>	1	□Yes 2 <b>X</b> 0No 3□	Probably 4 Unknown
plet		0			As an 24b. Were	autopsy findings available
Som				pe	erformed? death	1?
Be	examiner?	Hospital:	0			
		1 □ Inpatient 2 □	Envoulpatient 3 DOA	4 Mursing Home 5 ☐ H		(pecify)
atlor						
THE ST	determin	288. Place of injury - At n	ome, farm, street, factory, office	28f. Locatio City or	n (Street and Number or Town, State)	Rural Route Number,
S	292 Cartifier 1 Cartifuing	Physician: To the best of my kee	wilden death accurred at the	and data and place, and due to t	the equipols) and manner	an stated
dica	(Check only 2 Medical Ex	aminer: On the basis of examina	tion and/or investigation, in my	opinion, death occurred at the tin	ne, date and place, and o	as stated. due to the cause(s)
9	29b. Signature and title of certifier		29c. Licen	se number	29d. Date signed (Mo	onth, Day, Year)
2		0 1/ 1	$\Omega$	1333)	16/11/	2015
2	Some C	parke. 1	-D			
2	30. Name and address of person w	no completed cause of death (Iter	n 23a) (Type, Raint)	Ho-Ph	MD 20	940
State	30. Name and address of person with the state of the stat	no completed cause of death (Iter	in Berry	h Heights	MD n	960

			For State Registrar	State of Ma	aryland 7	Departm Certific			Mental H	ygiene Reg. No	1111-	35353
	Physici	an	1. Decedent's Name (First, Middl	e, Last)					2. Date of D Month	eath Day	y Year	3. Time of Death
	/Medic		Deborah	Marie	Wils				Octob			11:26 A M
7.	Examin	er	4a. Facility Name (If not institution			_		r Location of Dea	ath	4C.	County of Death	1
	Funeral		Easton Memoria 5. Social Security Number		e (In yrs. last	birthday) If Ur	aston	If Under 24 Hr	s. 8. Date of 8	irth	Talbot 9. Birth	place (State or Foreign
ja,	Funeral Director		220-68-7862	1□M 2以F 4	8	Yrs. Mon	ths Days	Hours Mir	oct.15	ay, Year) 5,195	Cou	intry) rland
	D >		Usual Residence of Decedent		10a City T	own or Location						10d. Inside City Limits
	shor shor	ō										1 A Yes 2 □ No
	28a-f	Director	Maryland Carol  10e. Street and Number	.ine	F	ederals	burg Zip Code			10a, Cit	izen of What Cou	untry?
	3a or		110 Interface	λ 170			21632	)			USA	•
	death	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13. Was D			(Specify Yes or Narto Rican, etc.)	lo-	14. Race - Amer	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, I'm Medical Exaction must be notified at Appear.	þ	1 ☐ Never Married 2 🛣 Mar 3 ☐ Widowed 4 ☐ Divorced	ried 1 ☐ Yes 2 🐧 N	No		specify Cub.	Specify:	arto nicari, etc.)		Black, White Specify:	3lack
Š	72 ho	Completed		nt's Education est grade completed)	1	6a. Decedent's	Usual Occup	ation during most of w	rorkina	16b. K	ind of Business/I	
2	ithin Jen	nple	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. DO NO	T use retire	d)				
ณ	filled w Hygier other th	ပိ	12 17. Father's Name (First, Middle,	(act)		Assem	bly V	Vorker	ame (First, Midd	le Maiden	Toy Fac	ctory
and	d be f	o Be	-						a (1 1/2), 1/11/20.	_		
Maryland	should Me mark	J.	Harvey 19a. Informant's Name/Relations	Smith ship (Type, Print)	1	19b. Mailing Add	ress (Street	Mary and Number or R	Rural Route Num		rett or Town, State, Z	ip Code)
	alth a		Rolonda Bar	rett / Daugh	ter 2	2354 Eut	aw Pla	ice. Apt	. B.Balt	imor	e.Marvla	and 21217
Sre,	of Health of Health litem 27 I		20a. Method of Disposition  1 Burial 2 Cemation		20b. Place	e of Disposition etery, crematory	(Name of		Date		ocation - City or	
<u>Ĕ</u>	Pag ment ant: It ury o	-	4 Donation 5 Other (S		Spr	ing Gro	ve Cer	n. 10-	29-2005	De	nton,Maı	yland
Baltimore,	permit. Depart Import any Inj		21. Signature of Fune al Service	Licensee		Ren	nie Sr	ss of Facility nith Fun In Stree	eral Hon	ne ock.M	arvland	21643
- 5°.	414		23a, Part1. Enter the disease, o	or complications that caused tonly one cause on each lin	the death. [							Approximate Interval Between
B	Pnysician		Immediate Cause (Final disease or condition	Cocaine I	ntoxicat	tion compl	Licating	Atheroso	lerotic C	ardiov	ascular Di	Onset and Death
*	/Medical Examiner		resulting in death)	Due to (or as	a consequen	nce of):						
24.0	Lxammer	_	Sequentially list conditions,	b. Due to (or as	a consequen	ico of):						
	ted nsit	Examiner	if any leading to immediate cause. Enter Underlying Cause (Disease or injury	2 Due to (or as	a consequen	ice or).						
	al-trai	xar	that initiated events resulting in death) Last	c. Due to (or as	a consequen	ice of):						
68760,	icate be executed physicien and s the burial-transit	dicai		d								
		W	IL ELMAI C.									
Вох	The law requires that the death certifica ste has been signed by the attending pr page 2 should be detached for use as it	Physician/M	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at	2 Fetal de	ath 3 Ectop	ic pregnancy	,			23d. Date of deli Month	very Day Year
O.	the de	iysic	1 □ Yes 2 □ No 9 ဩùnknown	9□ Unknown	time of death	11 3 D O(116	r (specify) _					
S,	res that igned by be deta	by Pr	Part II. Other significant conditi	ions contributing to death b	ut not resultir	ng in the underlyi	ng cause giv	en in Part I.	23e. Dio	tobacco (	use contribute to	the cause of death?
rds	w require: been sig should be	ed b							. 10	Yes 2	□No 3□Pro	obably 4 Qunknown
Vital Record	law re as bee 2 sho	Completed							24a. Wa	is an opsy	24b. Were au	topsy findings available ompletion of cause of
Œ.	The ete ha	ĕ							per 1 Yes	formed?	death?	
/ita	Physician: rthis certifice ral director, I	Be	25. Was case referred to medical examiner?				104		eath (Check onl)	оле		
<del>_</del>	Physi this o	2	1 X Yes 2 □ No 27. Manner of Death	Hospital: 1 - Inpatie	ent 200 ER	Outpatient 35 b. Time of Fire		4   Itursing	Home 5 ☐ Re 28d. Describe			ufy)
u	ding h. After funer	盲	1 □Natural 5 □ Pendi		y Year)	Injury 10:59 A M	Wo	yat Yes 2 <b>X</b> ∐No	unk	s now inqui	iy occurred	
Division of	Attending in deeth.	Certification:	3 ☐ Suicide 6 ☐ Could	not be 28e Place of Ini	ury - At home	a farm street fa		A	28f. Location	(Street ar	nd Number or Ru	ral Route Number,
ā	s after	Cert	4 Homicide	building, et	c. (Specify)	unk			City or I	own, State	y <b>unk</b>	
	To the Hospital or Attending Physician: The law within 24 hours after deeth. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical		ing Physician: To the best I Exeminer: On the basis of and manner sta	f examination							
	To th withir To th comp	Me	29b. Signature and title of certific	ar			29c. Licens			29d. Da	te signed (Month	Day, Year)
)			) Quat	) 4		and the state of t	00			0ct	ober 24	, 2005
			30. Name and address of person		leath (Item 23	3a) (Type, Print)	111 P	enn Stre	eet Bal			land 21201
	ac 5 -		31. Date filed (Month, Day, Year	RUB 10 M	ar's Signature			,				
	Sta	ate rar	OCT 2.			. 4						

ORIGINAL

			1 - State of Registrar	Maryland / Depa	artment of Health and M rtificate of Death		ene 005	35354
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	/Medic		WILLIAM WEIS			OCT	13 2005	- 110 P M
	Examir		4a. Facility Name (If not institution, give street and numb	per)	4b. City, Town, or Location of Death		4c. County of Dea	th
			Howard County General		Columbia		Howard	
	Funeral		¹¥⊓M 2∏ F	. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, )	/ear) 9. Bir	thplace (State or Foreign ountry)
	Director	ļ	Usual Residence of Decedent	86 Yrs.		Aug 6, 1	919 New	York
	land ow		10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	Mary f sh	ğ	Maryland Howard	Ellicott	City			1 □ Yes 2X No
	r 28a	Director	10e. Street and Number	EIIICOLL	10f. Zip Code	100	g. Citizen of What Co	ountry?
	h wit		8700 Ridge Road #319		21043	U	SA	
	72 hours after death with the Maryland neturel", or Hems 23e or 28e-f show dical Examinar must be notified at	Funeral	11. Marital Status 12. Was Deceding	ent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - Ame	
စ္	after or Ite		1 ☐ Never Married 2 ☐ Married 1 ☐ Xeves 2	ΠNo	f Yes, specify Cuban, Mexican, Puento	Hican, etc.)	Black, Whit	·
5-0036	ours irelt,	d by	3 ☐ Widowed 4 ☐ Divorced Year or Date	es 1941 – 45	1 ☐ Yes <b>②</b> CXNo Specify:		Specify: Whi	te
5-	72 h "netu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupation kind of work done during most of worki DO NOT use retired)	ng 16	b. Kind of Business	/Industry
12	within ene. then "	mp	Elementary/Secondary (0-12) College (1-4	or 5+)				
2	filed withii Hygiene. other then ent, The M		17. Father's Name (First, Middle, Last)	secur	ity Guard  18. Mother's Name			Manufacture
Maryland 2121	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. item 27 Is marked other then "neturel", or Items 23e or 28e-f show other treumatic event, the Medical Examinar must be notified at	Be.	William Nelson Weis		Mildred S		iden Sumame)	
7	and Me Is mark	ဥ	19a. Informant's Name/Relationship (Type, Print)	19h Mailir	ig Address (Street and Number or Rura		City or Town State	Zin Codol
<u>s</u>	and 2 sealth ar n 27 is		Jean Tillman/daughter					an annual and
ā	of Health item 27		20a. Method of Disposition	20b. Place of Dispo	Buckskin Wood Driv sition (Name of natory or other place) Octo	ber 15	c. Location - City or	10 21042 Town, State
9			1 ☐ Burial 2 【XCremation 3 ☐ Removal from Standard Companies 1 ☐ Other (Specify)	ate )	· ·		donton M	amiland
Baltimore,	artin orta inju		21. Signature of Funeral Service Licens		Name and Address of Facility Oing Home Crematio		denton, M	
m	Dep my eny		Devel French	M01251 C	larksville, MD 210	n Service	e P.O. Book	ox /84
			23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each	ised the death. Do not enti	er the mode of dying, such as cardiac o	r respiratory arres	t,	Approximate Interval Between
	Pnysician i	i E u	Immediate Cause (Final disease or condition	AUSCLEA. TTE	CARDISTALLIAN DI	1-30 c	7	Onset and Death
	/Medical Examiner		resulting in death)	as a consequence of):	CHILDING PA	JC JIJK		years
į.		,	Sequentially list conditions.					
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Unserlying Cause (Disease or injury	as a consequence of):				
	and I-tran	Examiner	that initiated events resulting in death) Last  Due to (or					
68760,	ificate be executed g physician and as the burial-transit		333 13 (3.	as a serios querios 51/1				
687		edicai	d.					
Box		Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outco		23d. Date of del	iverv		
m	death a atte d for		in the past 12 months?	it at time of death 5	Ectopic pregnancy Other (specify)		Month	Day Year
0	at the de by the tached	hys	9 Unknown 9 Unknow	n				
S, P	law requires that the death cert as been signed by the attendin 2 should be detached for use	by P	Part II. Other significant conditions contributing to deat	th but not resulting in the ur	nderlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
rd	w require been sig should b		PARKIASUN'S DISM	se		1 🗆 Yes	2 □ No 3 <del>□ P</del> 1	obably 4 □Unknown
000	law requas been 2 should	ompieted				24a. Was an	24b. Were au	topsy findings available
Ä	о <u>г</u> о	mo:				autopsy performe 1 ☐ Yes 2 €		completion of cause of
of Vital Record	icien: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?		26. Place of Death		13.55	20,10
>	1 N	2	1 Yes 2 No Hospital: 1 Imp	atient 2 ER/Outpatien	t 3 DOA Other: 4 Nursing Hor	ne 5 🗆 Residend	e 6 □Other (Spe	cify)
	ding Pt h. After th funeral	on:	27. Manner of Death  1 Chatural 5 □ Pending 28a. Date of 1 (Month,	Injury 28b. Time of Day Year) Injury	28c. Injury at Work?	28d. Describe how	injury occurred	
<u>si</u>	ottendi death. ctor: A / the fu	cati	2 Accident investigation		M 1 Yes 2 No			
Division	or A	Certification:	determined 286. Place of	Injury - At home, farm, stre , etc. <i>(Specify)</i>	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	urs aral led		29a. Certifier Certifying Physician: To the be	act of my knowledge do-th	occurred at the time, date and place, a	and due to the	20/2) 20/1	
	24 hc 24 hc Fun etely	edical	(Check only one) 2 Medical Examiner: On the basi and manner	s of examination and/or inv	estigation, in my opinion, death occurre	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the Hosp within 24 hor To the Fune completely fi	Me	29b. Signature and title of confier		29c. License number	29d	. Date signed (Montl	n, Day, Year)
A			> Kg_no		D51860	1	CT 13,	2005
			30. Name and address of person who completed cause of	of death (Item 23a) (Type, I	Print)	0	-10,	
			TOWATHAN FISH MO 10	700 CHARTER	DAINE #200 Co	CUMBIA	MD 7/04	4
	Sta		31. Date filed (Month, Day, Year) 32. Reg OCT 1 9 2005	ar's Signature	1			
	Registr	ar	OC1 1 9 2005	seem st.	Goarles			

			For Amend Item	233 ten p	aryland / 6	891 (11912) Certificate o	<b>Obditio</b> f Death		ne UU5	35355
*	* *	*	Decedent's Name (First, Middle, La	st)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Mabel J. Yoder					10	19 05	8:10 A.M.
74	Examin		4a. Facility Name (If not institution, giv SACCED NEAC	+ Hospita	al	Cum	or Location of Death		4c. County of Dea	ny
	Funeral		5. Social Security Number 6. S	Gex <sup>1</sup> 7.Ag I□M 2 <b>⊊</b> F	e (In yrs. last bir	thday) If Under 1 Ye.  Months Day		8. Date of Birth (Month, Day, Y	ear) C	rthplace (State or Foreign ountry)
m <sub>Q</sub>	Director		168-54-1899 Usual Residence of Decedent		72			Aug 29,	1933   Pen	nsylvania
	irylan ihow		10a. State 10b. County		10c. City, Tow					10d. tnside City Limits
	Ba-f s	Director	PA Somerset				yersdale	100	. Citizen of What C	1 Yes 2 No
36	th with t	al Dir	10e. Street and Number 191 Moser Road			10f. Zip Code	552	100	USA	
	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show rdical Exeminer must be multiled at	by Funeral	11. Marital Status  1 ☐ Never Married 2 Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces?  1 Yes 2X If Yes, Give Year or Dates.		13. Was Decedent of If Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puert No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh Specify:	
21215-0036	72 hou		15. Decedent's E (Specify only highest gr	ducation ade completed)	16a.	Decedent's Usual Oct (Give kind of work do	cupation	rkina 16	b. Kind of Business	s/Industry
21	⊂ ∰	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO NOT use ret	ired)			
	77 6 5 50		8th 17. Father's Name (First, Middle, Last	•)		Homema		ne (First, Middle, Ma		n Home
Maryland	d la b	To Be	Jacob S. Yoder	,			Fannie			
ary	S D E E	-	19a. Informant's Name/Relationship	Type, Print)	19b	. Mailing Address (Stre			City or Town, State,	Zip Code)
	t and 2 Health a lam 27 is		Cloyd E. Yoder,	Husband		91 Moser Ro				
altimore,	00-		20a. Method of Disposition  1  Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Speci		1	Disposition (Name of ry, crematory or other p in View Cet			c. Location - City o	
Balti	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service trice	nsee			dress of Facility Nen-Dixon Hw			Inc. isbury, PA
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com	plications that caused	d the death. Do					Approximate 558 Interval Between
										Onset and Death
4			1	Due to (or as	a consequence	of): Ver	tral ha	Yn.a		19 dans
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence of):			11000			
	ficate be executed physicien and s the burial-fransit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c						
50,	ficate be executed physicien and is the burial-fransit									
68760,	icate t physics the t	edicai	•	d						
Box	death certi e attending rd for use a	Physician/Me	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death	3 ☐Ectopic pregna 5 ☐ Other (specify,			23d. Date of de Month	elivery Day Year
, P.O	res that signed by be deta	by Ph	Part II. Other significant conditions	contributing to death t	out not resulting i	n the underlying cause	given in Part I.	23e. Did toba	cco use contribute	to the cause of death?
rds	w require: been sig should b		chlome q	monadal	Mina	,		1 🗆 Yes	2 No 3 □ F	robably 4 Unknown
Vital Records,	e la has je 2	Completed	conjustice !	test !	aspirati	on pneumor	uia	24a. Was an autopsy performe	prior to	autopsy findings available completion of cause of
alF			25. Was case referred to medicat	1 Pasarble	Carp 16 12	-		1 ☐ Yes 228	No 1 ☐ Ye	s 21 No
:5	sicial s certi	To Be	examiner?	Hospital:	ent 2 ☐ ER/Oi	utpatient 3 DOA	Other	ath <i>Check only one</i> flome 5 Residen	ce 6 ∏Other (So	ecify)
sion of	or Attending Physician: ifter death. Director: After this certifics in by the funeral director, p		27. Manner of Death  12. Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ury 28b.	Time of 28c. Injury	Nork?	28d. Describe how		
Divisi	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not l 4 Homicide determined	28e. Place of In	jury - At home, fa tc. (Specify)	arm, street, factory, offi	СӨ	28f. Location (Stre City or Town,		Rural Route Number,
	To the Hospital within 24 hours of To the Funeral completely filled	edicai C			of examination ar	e, death occurred at the				
29b. Signature and title of certifier						29c. Lic	29c. License number 29d.			oth, Day, Year)
12 Chebel , MD D34362					34362	10-19-05		25		
	1		30. Name and address of person who	completed cause of	death (Item 23a)			eland, m	102150	2
~15	Sta		31. Date filed (Mohth, Day, Year)	32. Regist	rar's Signature		2011.00		30.00	
44	Regist	rar	06124	7007	Eura 15.	Brooke				

			1- State of Maryland / Dep	partment of Health and Mertificate of Death	lental Hygie رجag. ا			
	Physici /Medic		1. Decedent's Name <i>(First, Middle, Last)</i> John Henry Young		2. Date of Death October	er <sup>D</sup> 195,2005 8:30 AM <sub>M</sub>		
	Examin		4a. Facility Name (If not institution, give street and number) Pineview Nursing Home	4b. City, Town, or Location of Death Clinton		4c. County of Death Prince Georges		
	Funeral Director		5. Social Security Number 218-16-3076 6. Sex 120 F 83 Yrs.	y) If Under 1 Year If Under 24 Hrs.  Months Oays Hours Min.	8. Date of Birth Ochlonth Day, Ye	9. Birthplace (State or Foreign Mary Land		
basical	f show	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or  MD Prince Georges Brandy			10d. Inside City Limits 1 ☑ Yes 2 ☐ No		
with the	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. It marked other then "naturel; or Items 23a or 28a-f show aumatic event, the Madral Examinational parties and filed.	Director	10e. Street and Number 13907 Missouri Ave.	10f. Zip Code 20613	10g.	Citizen of What Country?		
36 after death		by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	I. Was Decedent of Hispanic Origin? (Spriff Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black		
215-0036	e. an "natural" Medical Ex	Completed b	3 ☐ Wildowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education 16a. Dec	edent's Usual Occupation re kind of work done during most of worki DO NOT use retired)	ing 16b	. Kind of Business/Industry		
d 2121	Hygiene Hygiene othar the	Ве Соп	12 17. Father's Name (First, Middle, Last)	Farming 18. Mother's Name	e (First, Middle, Maid	Self Employed  Jen Sumame)		
Maryland	d Menta narkad natic ev	To B	John O. Young		ietta Ha	···		
≥ 5	± 2, ₹			iling Address (Street and Number or Rura 4 Brandywine Rd				
ore .	0		1 M Buriai 2   Cremation 3   Hemoval from State   _	ematory or other place)		Location - City or Town, State Linton, Md.		
Balti	Department Important: If any injury or once.		21. Signature of Fund al Service Lightsey	22. Name and Address of Facility .dams Funeral Ho		quasco, Md 20608		
	of .		23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	1		Approximate Interval Between Onset and Death		
	i he law requires that the ate has been signed by th page 2 should be detache	Examiner	disease or condition resulting in death)  a. Due to (or as a consequence of):	ERS DISEASE	ENDS	MEE		
uted			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
8760,		dical Ex	resulting in death) Last  Due to (or as a consequence of):  d					
. Box 6		Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year		
ecords, P.		by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?  2 No 3 Probably 4 Unknown		
Ĭ g		Completed			24a. Was an autopsy performed:	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No		
of Vital	is certificate director, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ▼ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	26. Place of Death		6 □Other (Specify)		
	ing After une	ation; T	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation	of 28c. Injury at 2	Vork?			
DIVISION	s after death al Director: , ad in by the f	Certification	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)		
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Tothe	within To the comple	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)		
28	3		30. Name and address of person who completed caused death (Item 20a) (Type FLANCTNE D. HISGS - SHIPMAN M	p. Print)	(-)0 R-1	FUILLE, MD21705		
	Sta Registr		Stephen D. Hiss Stipmen M. 31. Date filed (Month, Day, Year)  OCT 1 9 2005  Manual M. 2005	Cocatio	e ur. Del	BVILLE, MYDLI 103		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Edith Mae Young September 28, 05 1:30 p<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5412 Brenner St Capitol Heights Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9-13-1940 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1□ M 2₽F Yrs. 65 Director D.C 579-52-3207 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits ral, or Itams 23a or 28a-f show Examiner must be notified at 1 Yes 2 □ No Directo Prince George's Capitol Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5412 Brenner St. 20743 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, 2 No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🙀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No Specify: Completed by Specify: Black 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Domestice Techician Medical 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Itam 27 Is marked oth any jiny or other traumatic evant <u>anks</u>. Be Charles Banks Roberta Lamb Banks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5412 Brenner St, Capitol Heights Md 20743 19a. Informant's Name/Relationship (Type, Print) Robert Lee Young - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other pla Glen Wood Cem. 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 10-8-2005 Washington, DC \* 4 □ Donation 5 □ Other (Specify) 21. Signalue di Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility D.L. McLaughlin's Funeral McSvc. Inc 1425 Md Ave, Ne, Wash DC 20002 lications that caused the death. Do get enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part1. Enter the disease, or 7 m shock, or heart failure. List in a Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PANCREAS **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Cher (specify) 4☐ Pregnant at time of death the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by MELLITUS 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autoosy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2X No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 XNo 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred After t 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and plot of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dun MI 10 D0030583 Van 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. John N Van Dam, 650 Pennsylvania Ave, SE # Wash DC 20003 MD, MPH 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

OCT 1 8 2005

Division of Vital Records, P.O. Box 68760

State of Maryland / Department of Health and Mental Hygiere 0 0 5 35358 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Julian Zelaya - 2005 10 -17 04:26 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital 01ney Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 ☐ F If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Months 57 Yrs. 220-31-3131 Director 05-15-1948 El Salvador Usual Residence of Decedent with the Maryland in then "natural", or Itame 23a or 28a-f ahow the Medical Examinat must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Silver Spring 1X Yes 2 No Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3740 Belpre Road #13 20906 death Funeral Salvador Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Item any injury or other traumatic event, the Medical Exemples once. 1 □Yes 2 X No If Yes, Give 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1X Yes 2□ No Specify:Salvadoran Specify: White þ 3 Widowed 4 Divorced leted 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Compl Elementary/Secondary (0-12) College (1-4or 5+) 0 Restaurant Cook 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pablo Zelava Juana Diaz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3740 Belpre Road #13 Silver Spring, Maryland, 20906 Ana Lidia Zelaya/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery 10-22-05 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility W. H. Bacon Funeral Home, Inc. Manda 3447 14th St., N.W. Washington, D.C. 20010 acon CC361 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician THEROSCLEROTIC LARDIOVASCULAR MISEASE TWO Months /Medical Due to (or as a consequence of). Examiner yper tension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (b) as a consequence of) Examine sician and burial-transit certificate be executed DLABETES Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death Check only one examiner? 1 X Yes 2 ☐ No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 2 XER/Outpatient 3 DOA this the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? of or Attending Parties death. Certification 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Tes 2 No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours aft To the Funeral DI 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) D00030414 OCTUBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRINCE PHILIP DR OLNEY MARYLAND ERRING mn 0 31. Date filed (Month, Day, Year) Registrar's Signature. State OCT 1 9 2005 Registrar

			1_ For State	State of Mary	land / Depa	artment of H	Health and M	-		5 35359
			Registrar		Cel	tificate of	Death		eg. No.	
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	how		10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits
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0	er de	Funerai		12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H f Yes, specify Cubi	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		merican Indian, /hite, etc.
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Brown re, Maryland	and and me		19a. Informant's Name/Relationship (Typ	oe, Print) Son	19b. Mailin	g Address (Street	and Number or Flura	al Route Number	City or Town, Stat	e, Zip Code)
∠ Σ	of Health of Health item 27 i		Mr. Charles E. Bro				Road Ab	ingdon,	Maryland	21009
Baltimore,	of He		20a. Method of Disposition 1∑ Burial 2 □ Cremation 3 □Ri	emoval from State	Ob. Place of Dispo cemetery, cren	sition (Name of natory or other plac	ce)	Date	20c. Location - City	or Town, State
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Division of Vital Records, P.O.	Se Ded	by	Part II. Other significant conditions con	tributing to death but no	t resulting in the u	iderlying cause giv	en in Part I.			e to the cause of death?
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	2		Dr. Kamlun Augen	ng, 9000 F	rankli	1 Sazuar	e prive F	saltimo	remn:	21237
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H	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthda 2 F 53 Yrs.	Months Days Hours Min (A	ate of Birth Month, Day, Year 1 y 1 19	r) Cour	place (State or Foreign ntry) yland							
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Maryland 2	should be filed within and Mental Hygiene. s marked other than umatic event, the Mental count.	To Be C	17. Father's Name (First, Middle, Last) Frank Branford	18. Mother's Name (Firs Lucille Mo		,								
ary			19a. Informant's Name/Relationship (Турө, Print) 19b. Ма	tiling Address (Street and Number or Rural Rou	ite Number, City	or Town, State, Zip	Code)							
	tra		Lucille Gillis(Mother) 100	Colney Dr. Annap	olis,	Md. 214	03							
J.				position (Name of Pate rematory of other place)	20c. t	Location - City or To	own, State							
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Baltimore,	permit. Pag Department Important: I any injury o			22 Name and Address of Eacility Wm. Reese & Sons M 821 West St. Annap	fortuar	y, P.A.	01							
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Division		Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28f. Lo	ocation (Street a. lity or Town, Stat	nd Number or Rura	l Route Number,							
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	중 수 필 등	Medical (	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and du investigation, in my opinion, death occurred at t	ue to the cause(s the time, date an	i) and manner as st id place, and due to	ated. the cause(s)							
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4	1		Channing Paller. The Johnstonk	ens Hospital, 600/	Onethelia	If chan's	- March							
	Sta	Channing Taller, Medical Doctor Res-000 October 18 2005  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Channing Paller, The Johns Hopkens Hospital, 600 North Wolfe Street, Mary bind  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature												
	Registr	_	NOV 0 2 2005   Description of A	pode			0 /							

			State of Maryland / Dep.  1- State Amend Item 10a-f per fn G849 II-	artment of Health and Mental Hy 72-05, tas rtificate of Death	ygiene Reg. No. 005 35361								
			Decedent's Name (First, Middle, Last)	2. Date of D	eath 3. Time of Death								
	Physici		Madge C. Burris	Septem Septem	ber 13, 2005 8:10pm M								
	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death								
			Health Care & Retirement	Hyattsville	Prince Georges								
	Funeral		5. Social Security Number 6. Sex 1 M 2 K 7. Age (In yrs. last birthday) 97 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of B Months Days Hours Min. Fe Month.	irth 9 Birthplace (State or Foreign								
	Director		3/9-18-99/3	reb. 10	Maryland Maryland								
	and *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	ocation	10d. Inside City Limits								
	Aanyl f sho	ō	- Mp vv	Prince Georges	1v Yes 2 □ No								
	28a-	Director	DC MD Hyattsville Washingto	10f, Zip Code	10g. Citizen of What Country?								
	3a or		10e, Street and Number 6500 Riggs Road 4705 8th Street	<del>20011</del> 20783	United States								
	within 72 hours after death with the Maryland ene. then "naturel", or Items 23a or 28a-f show the Medical Exe uther Lust be motified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian,								
9	or Ite	T.	1 □ Never Married 2 □ Married 1 □ Yes 2 1 No	1 ☐ Yes 2 ☑ No Specify:									
03	rel', o	l by	3 ₩ Widowed 4 Divorced Year or Dates:	TET TOS ZIX NO Specify.	Specify: Black								
21215-0036	72 h 'natu	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working	16b. Kind of Business/Industry								
121	hen.	gu	Florentes (Conseder (C.12) College (1.4er Ft)	ir Dresser	Self -Employed								
	lled v lygie her t		17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middl									
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 Is marked other then "naturel", or Items 23a or 28a-f show other treumatic event, I've Medical Execution Last be notified at	Be c	William Copeland	Rose Simpson	o, Maradin Barnamay								
7	should ad Me mark matik	ဥ	19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Rural Route Num	ber, City or Town, State, Zip Code)								
Ma	od 2 s lith ar 27 ls r treu			B Grits Mill Dr. Rockvil									
ē,	Hea Hea Hem Stem		20a Method of Disposition 20b, Place of Dispo	osition (Name of Date	20c. Location - City or Town, State								
9	Pages nent of I int: If it		1 ☐ Burial 2 ☐ Yremation 3 ☐ Removal from State Riverdal 6	e Park Crem. 9/27/05	Riverdale, MD								
Baltimore,	그 등 문 등		21. Signature of Funeral Service Licensee 2:	Austin Royster Funeral F	In								
m	Departi Departi Import any ir		at the	3821 14th Street Nill Wash	ington DC 20011								
			23a. Part1. Enter the disease, of complications that caused the death. Do not en shock, or head failure. List only one cause on each line.	ter the mode of dying, such as cardiac or respiratory	arrest, DC Approximate								
	Physician		Immediate Cause (Final disease or condition CAND	MORESPIRATORY BY	AREST Onset and Death								
	/Medical		resulting in death)  Due to (or as a consequence of):										
ш	Examiner		Sequentially list conditions, b.	ENTIA									
	De tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
	and I-tran	хаш	resulting in death) Last  C. Due to (or as a consequence of):										
8760,	death certificate be executed e attending physician and of for use as the burial-transit				1)								
687	icate phys s the	Physician/Medical	d										
×	leath certifica attending ph I for use as th	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery								
Вох	death atter	ciar	in the past 12 months?	□Ectopic pregnancy □ Other (specify)	Month Day Year								
0		hys	9 Unknown										
<u>ر</u>	res that igned be be det	by P	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I. 23e. Did	tobacco use contribute to the cause of death?								
rd	w require been sig should b	ed t		1	Yes 2 No 3 Probably 4 Unknown								
Records,	law requires that the as been signed by th 2 should be detache	Completed		24a. Wa	s an 24b. Were autopsy findings available prior to completion of cause of								
Ä	icten: The lay certificate has rector, page 2	mo			formed? death?								
Vital	ien: artifica ctor,	Be C	25. Was case referred to medical examiner?	26. Place of Death (Check only	r one)								
of V	Physicien: this certific ral director,	10	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	A	sidence 6 Other (Specify)								
	ding P. After ti funera	on:	27. Manner of Death 1 X Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) Injury	Work?	e how injury occurred								
sio	Attending r death. sctor: After by the fune	cati	2 Accident Investigation 3 Suicide 6 Could not be 280 Place of Injury. At home, farm, st	M 1 Yes 2 No	(Street and Number or Rural Route Number,								
Division	or At after of Direct in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		(Street and Number of Aural Houte Number, own, State)								
	To the Hospital or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 (X Certifying Physician: To the best of my knowledge, deat	th occurred at the time, date and place, and due to the	e cause(s) and manner as stated								
	24 hos 24 hos Fun etely	Medical	(Check only 2 Medical Exeminer: On the basis of examination and/or in and manner stated.										
	To the within 2 To the comple	Me	29b. Signature and title of Certifier	29c. License number	29d. Date signed (Month, Day, Year)								
	1	+	D0058290 September 15, 2005										
1	10		30. Name and address of person who completed cause of death (Item 23a) (Type,	•									
	١,		Dr. Suresh K. Muttath, 4203 Queenbury	rie Road Hyattsville, MD	20781 Room #4203								
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	estil									
	Regist	alr	31. Date filed (Month, Day, Year)  NOV 0 2 2005  32 Registrar's Signature										

Decomers value (First, Maddle, Led)   Physician (Aledical Examiner)   Ale Decomers value (First, Maddle, Led)   Physician (Aledical Examiner)   Ale Decomers value (First, Maddle, Maddle, Led)   Physician (Aledical Examiner)   Ale Decomers value (First, Maddle, Maddle, Led)   Physician (Aledical Examiner)   Ale Decomers value (First, Maddle, Maddle, Led)   Physician (Aledical Examiner)   Ale Decomers value (First, Maddle, Maddle, Led)   Physician (Aledical Examiner)   Ale Decomers value (First, Maddle, Maddle, Led)   Physician (Aledical Examiner)   Ale Decomers value (First, Maddle, Maddle, Led)   Physician (Aledical Examiner)   Aled Decomers value (First, Maddle, Maddle, Led)   Physician (Aled Decomers)   Aled Decomers value (First, Maddle, Maddle, Led)   Physician (Aled Decomers)   Physician (Aled De				For State	State of Ma	ryland / Depa <i>Cel</i>	artment of H			21115	35362
Scrimmer  Finance  Fi				Registrar  1. Decedent's Name (First, Middle,	Last)						3. Time of Death
42 - Cherry of Dears of Control Contro				ZENA K	4TE BO	EIT			Month		
DITION OF THE PROPERTY NAMED AND ADDRESS				4a. Facility Name (If not institution, of	ive street and number)		4b. City, Town, or	Location of Death	001-		
Second security Australia   Second security Australia   Second security Australia   Second security Australia   Second security Australia   Second security Australia   Second security Australia   Second security Australia   Second security Australia   Second second security Australia   Second second security Australia   Second second	1	LXaIIIII	CI	GREATER RAC	44	ENTRY CT	1 TOW	SON		BACI	IMORE
Discretory    Top   State of Proceedings   Top		Funeral		5. Social Security Number 6	. Sex 7. Age	(In yrs. last birthday)			8. Date of Birth	year) 9. B	irthplace (State or Foreign
To share the control of the country				216-22-4613	1 □ M 2 X F	<b>88</b> Yrs.	Months Days	Hours Min.	5-6-1	917 0	TROTICIA
To the formation of Disputer Privision Information Name Relationship (Type, Primit)  15b. Mailing Address (Streat and Number of Priusi Route Number. City or Town, State. Zero Cade)  MANUALD J. J. Committee		D .				10a City Town as I					10d Incide City Limite
To the formation of Disputer Privision Information Name Relationship (Type, Primit)  15b. Mailing Address (Streat and Number of Priusi Route Number. City or Town, State. Zero Cade)  MANUALD J. J. Committee		anyla shov	5	Toa. State Tob. County		Toc. City, Town of Lo	cation	—			
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To the formation of Disputer Privision Information Name Relationship (Type, Primit)  15b. Mailing Address (Streat and Number of Priusi Route Number. City or Town, State. Zero Cade)  MANUALD J. J. Committee	:	eath	eral	11 Marital Status	12. Was Decedent Fy	ver in U.S. 13.1	Was Decedent of Hi	spanic Origin? (Spe	ecify Yes or No-		nerican Indian.
To the formation of Disputer Privision Information Name Relationship (Type, Primit)  15b. Mailing Address (Streat and Number of Priusi Route Number. City or Town, State. Zero Cade)  MANUALD J. J. Committee	10	Titen	ᆵ		Armed Forces?		f Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		
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A	<b>\(\frac{1}{2}\)</b>	houfe d Me mark matic	۲	19a Informant's Name/Relationshir			n Address (Street a	and Number or Rura	Il Route Number	City or Town State	Zin Code)
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A	<u>ත</u>	Hea Hea tem		111111111	,	20b. Place of Dispo	sition (Name of		Date 2	0c. Location - City	
Physician / Medical Examiner    Physician / Medical Examiner   Physician / Physic	9	Pages ent of ht: If i						·	1-05	BAITEN	MRE MY
Physician / Medical Examiner    Physician / Medical Examiner   Physician / Physic	Ħ	mit. I					-				
Physician Middle Examiner  Physician Middle Examiner  The Court (Practice) of heart failure conditions as considered in the cause of death of the conditions of the cause of death of the cause of dea	ä	Par L S		1/ /withour	X. Na	12- 4	as when	AY HOTS	AV, 1	BACTO,	MD 2/207
Immedia Cause (Final disease or condition resulting in death   Due to (of as a consequence of):				23a. Part. Enter the disease, or co	emplications that caused to	he leath. Do not ent	er the mode of dyin	g, such as cardiac o	or respiratory arre	st,	Approximate Interval Between
Medical Examiner    Part   Par	F	Physician		Immediate Cause (Final	A.50:	To tion	' , )				Onset and Death
Sequentially list conditions, it seems to be proposed and straining of the conditions and the cause of the ca		/Medical			Due to (d) as a	consequence of):	11.00	11101116	~		10.0
The second of th		Examiner		Sequentially list conditions,	b						
The second of th		sit ag	luei	if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):					
Section   Sect		ecut and I-tran	хап	that initiated events	c	consequence of):					
FFEMALE   23b. Was decedent pregnant   1   Live bith 2   Fetal death 3   Ectopic pregnancy   1   Live bith 2   Fetal death 3   Ectopic pregnancy   1   Live bith 2   Fetal death 4   Pregnant at time of death 5   Other (specify)   23d. Date of delivery   Month Day Year   1   Live bith 2   Fetal death 5   Other (specify)   23d. Date of delivery   Month Day Year   1   Live bith 2   Fetal death 5   Other (specify)   23d. Date of delivery   Month Day Year   1   Live bith 2   Fetal death 5   Other (specify)   23d. Date of delivery   Month Day Year   1   Live bith 2   Fetal death 5   Other (specify)   23d. Date of delivery   Month Day Year   1   Yes 2	.09	be exician lician buria	alE								
OC 4 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  1   Yes   2   No 3   Probably 4   Unknown    24a. Was an autopsy findings available prior to completion of cause of death?  1   Yes   2   No 3   Probably 4   Unknown    24a. Was an autopsy findings available prior to completion of cause of death?  1   Yes   2   No 3   Probably 4   Unknown    24a. Was an autopsy findings available prior to completion of cause of death?  1   Yes   2   No 3   Probably 4   Unknown    24a. Was an autopsy findings available prior to completion of cause of death?  1   Yes   2   No 3   Probably 4   Unknown    24a. Was an autopsy findings available prior to completion of cause of death?  1   Yes   2   No 3   Probably 4   Unknown    24a. Was an autopsy findings available prior to completion of cause of death?  1   Yes   2   No 3   Probably 4   Unknown    24a. Was an autopsy findings available prior to completion of cause of death?  1   Yes   2   No 3   Probably 4   Unknown    24b. Was case referred to medical examiner?  1   Yes   2   No 3   Probably 4   Unknown    24a. Was an autopsy findings available prior to completion of cause of death?  1   Yes   2   No 3   Probably 4   Unknown    24a. Was an autopsy findings available prior to completion of cause of death?  1   Yes   2   No    24b. Was an autopsy findings available prior to completion of cause of death?  1   Yes   2   No    24b. Was an autopsy findings available prior to completion of cause of death?  1   Yes   2   No    25c. Place of Death (Check only one)  27c. Marriar of Death (Check only one)  28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Location (Street and Number or Rural Route Number, City or Town, State)  29d. Signature and title of certifier  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29	387	phys phys s the	odlo		d						
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Joyn Mills mo DO056156 October 29, 2005  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Suzarne Callamese 6665 NORTH Charles Street Baltimore, Maryland 21204	/ita	clan: ertific actor,							(Check only one	y	
Joyn Mills mo DO056156 October 29, 2005  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Suzarne Callamese 6665 NORTH Charles Street Baltimore, Maryland 21204	) t	hysi this c	မ		Inpatien		1 3LI DOA	4   Nursing Hor			pecify)
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Joyn Mills mo DO056156 October 29, 2005  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Suzarne Callamese 6665 NORTH Charles Street Baltimore, Maryland 21204	=	i or A after Direction by	ertii	4 Homicide determin	building, etc.	(Specify)	oot, lactory, office				
Joyn Mills mo DO056156 October 29, 2005  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Suzarne Callamese 6665 NORTH Charles Street Baltimore, Maryland 21204		spita nours nerai / fillec		29a. Certifier 1 Cartifying	Physician: To the best of	my knowledge, deatl	occurred at the tim	ne, date and place, a	and due to the car	use(s) and manner	as stated.
Joyn Mills mo DO056156 October 29, 2005  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Suzarne Callamese 6665 NORTH Charles Street Baltimore, Maryland 21204		he Ho n 24 I he Fu	edic		aminar: On the basis of e	examination and/or in ed.	vestigation, in my op	oinion, death occurre	ed at the time, da	te and place, and d	ue to the cause(s)
		To t withi To tl	Σ	9b. Signature and title of certifier	1						
	•	1		1 Soyn	n chh	mo	000	56150	0 0	ctobor	29, 2005
	1			0	no completed cause of de	ath (Item 23a) (Type,	Print)		> 11		1 / 2001
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Registrar NOV 0 2 2005						w # A	certi				

D				State of Maryland / Den		•	•				
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B	Physici	an	1. Decedent's Name (First, Middle, Las			2. Date of Death		Time of Death			
	/Medic		Larry	Barn		OCTOBER		45р. м			
1	Examin	ıer	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death BALTIMORE		4c. County of Death				
	3. 4		3201 MAGNOLIA AVE	7 Ago (In ura Ingé hirthdau)		8. Date of Birth	NA Ristolana	Chata as Favoire			
	Funeral Director		5. Social Security Number 6. Sec. 214-64-3833	ox ☑M 2□F  7. Age (In yrs. last birthday)  Yrs.  51	Months Days Hours Min.	(Month, Day, )	(ear) Country	State or Foreign			
	ow et		10a. State 10b. County	10c. City, Town or Lo	ocation		10d. In	side City Limits			
	Man,	tor	Md. NA	Balti	more		X	XYes 2∏No			
	3a or 28a	i Director	10e. Street and Number 3201 Magnola Ave		10f. Zip Code 21227	100	D. Citizen of What Country?				
	death	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. 13,	Was Decedent of Hispanic Origin? (Spe	cify Yes or No-	14. Race - American Inc	dian,			
920	72 hours after death with the Maryland Insturel', or Iteme 23a or 28a-f ehow Ucal Exacultat med be notified at	þ	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2127 No	If Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 No Specify:	nicari, etc.)	Specify: Black				
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other then "natural", or iteme 23a or 28a-f show or other traumatic event, the Medical Examinating the notified at	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	de completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ng 16	b. Kind of Business/Industry				
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/land	should be fill and Mental Hy marked oth umatic even!	To Be	17. Father's Name (First, Middle, Last) Wilton	Barnett	18. Mother's Name Mildred		Collins	i			
	nd 2 sho lith and h 27 ie ma r trauma	ľ	19a. Informant's Name/Relationship (7 Wilton Barnett,		ng Address (Street and Number or Rura $N_{ m N}$ . Ellwood Ave.,						
ē,	f Hea item other		20a. Method of Disposition	20b. Place of Dispo	osition (Name of matory or other place)	ate 20	c. Location - City or Town, S	tate			
Ë	Page lent o nt: If ry or		1√D Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	y Cemetery 11-3-	-05 m	undalk, Maryla	and			
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		21. Signature of Funeral Service Licent		2. Name and Address of Facility  March F.H. East	Balti		202			
60,	Physician /Medical Examiner and parial-transit	cai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. Atherosclerotic Ca  Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):	ardiovascular Disea	ise					
O. Box 68	death certifica e attending ph d for use as th	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day	Year			
ds, P.	uires that n signed t	d by P	Part II. Other significant conditions co	ontributing to death but not resulting in the u	underlying cause given in Part I.		cco use contribute to the cau	use of death?			
Division of Vital Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed by				24a. Was an autopsy performs	24b. Were autopsy fir prior to complete death?				
ita		Be C	25. Was case referred to medical		26. Ptace of Death	(Check only one)	7.0				
<b>\</b>	Physician: this certific ral director.	10	examiner? MY Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	nt 3□ DOA Other: 4□ Nursing Ho	m <i>e</i> 5 ☐ Residen	ce 6 X ther (Specify) S	CENE			
ion o	nding Pt ath. r: After the ie funeral	ation:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how	injury occurred				
Divis	el or Atte s after de si Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Roul State)	te Number,			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Example 1	ysician: To the best of my knowledge, deal iiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the cau ed at the time, dat	se(s) and manner as stated. e and place, and due to the c	:ause(s)			
	To th withir To th comp	Me	29b. Signature and title of certifier		29c. License number OCME	290	1. Date signed (Month, Day,	rear)			
			Fame 1 5 Sins	hall, mo	OOFILE	OC	TOBER 28,2005				
-			30. Name and address of person who of Pumeku E. Son	completed cause of death (Item 23a) (Type,	Print) 111 Penn Stree	t Baltin	more, Maryland	1 21201			
174	Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signature		<del> </del>					
	Regist	State									

	1- For State Registrer	e of Maryland /	Department of Certificate of			giene	5 35364
Physician	Decedent's Name (First, Middle, Last)  Eva June Bond				2. Date of De Month OCtobe	Day	Year G. 40 A M
/Medical Examiner	4a. Facility Name (If not institution, give street and	d number)	4b. City, Town,	or Location of Death	OCTOBE	4c. County	
	Baltimore Washington Med	dical Center	Glen	Burnie			Arundel
Funeral	5. Social Security Number 6. Sex 1□ M 2√	7. Age (In yrs. last bi	Yrs. If Under 1 Year Months Days		8. Date of Birt (Month, Pa June 14	h V. Year)	Birthplace (State or Foreign Country)
Director	Usual Residence of Decedent	00	115.		June 14	1937	West Virginia
yland	10a. State 10b. County	10c. City, Tov	n or Location				10d. Inside City Limits
the Mar 28a-f si number	Maryland   Anne Arundel	Glen	Burnie				1 Yes 2 No
with the Ma	10e. Street and Number		10f. Zip Code		1	10g. Citizen of W	/hat Country?
eath veath veath veral	712 Washington Avenue	Decedent Ever in U.S.	210			U.S.A.	e - American Indian,
1215-0036 within 72 hours after death with the Maryland ene. ne. ne. ne. ne. ne. ne. ne. ne. ne.	IT YA	d Forces? /es \$4∏ No s, Give	13. Was Decedent of If Yes, specify Cui		Rican, etc.)	Blace Specify:	k, White, etc.
hours a turnel; of all Examed by	Year Year	or Dates:	a. Decedent's Usual Occu	pation		16b. Kind of Bu	wnite
21215-00 ed within 72 hou ygiene. ygiene. it, the Madical Et. Completed	(Specify only highest grade completed in the complete (Specify only highest grade completed in the complete in		(Give kind of work done life. DO NOT use retir	a during most of work	ing	TOD. KING OF BE	Siliosamaasiy
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Maryland 21215-0036 Maryland 21215-0036 at 2 should be filed within 72 hours aff fills and Mental Hydison. The marked other three in natural; or Traumatic event, the Medical Exam To Be Completed by F	17. Father's Name (First, Middle, Last)			18. Mother's Name		Maiden Sumam	e)
ryla rould I wante marke	Harley Bell  19a. Informant's Name/Relationship (Type, Print	194	b. Mailing Address (Stree	Pollie	Lilly	or City or Town	State Zin Codel
Man Man Man Man Man Man Man Man Man Man	Ronald Bond- son	1 -	Willow Oak				31a16, 21p 0006)
S 1 ar other other	20a. Method of Disposition	20b. Place	of Disposition (Name of ery, crematory or other pla		Date		City or Town, State
Bond, altimore, mit. Pages 1 ar perfment of Hea portant: if Itam y injury or othe	1  ☐ Burial 2 ☐ Cremation 3 ☐ Removal to a ☐ Donation 5 ☐ Other (Specify)	TOTA State	wridge Mem.	1	2005	Elkrid	je, MD
Baltimore, Maryland 21215  Baltimore, Maryland 21215  permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if than 27 is marked other than "nany injury or other traumatic event, the Mod once.  To Be Complet	21. Signature of Funeral Service Licensee		22. Name and Addi Gary L. Ka 7250 Wash	ress of Facility aufman Fun ington Blv	eral Ho	me at Mi ridge. N	MP, INC. MD 21075
	23a. Part 1. Enter the disease, or complications t shock, or heart failure. List only one cause	hat caused the death. Do on each line.				-	Approximate Interval Between
Physician	Immediate Cause (Final disease or condition resulting in death)	LEN'E CAN	1CBP				Onset and Death
/Medical Examiner	Du Du	e to (or as a consequence	of):				
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5876( icate be physicie s the bur	d						° .
Division of Vital Records, P.O. Box 68 to Attending Physician: The law requires that the death certifical atter death.  Director: After this certificate has been signed by the attending phy in property that the functal director, page 2 should be detached for use as the ertification: To Be Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	s, outcome of pregnancy ive birth 2 Petal deatl		су		23d. Date	e of delivery hth Day Year
that the detected by the a	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Pregnant at time of death Jnknown	5 ☐ Other (specify)				,
ds, P.  uires that it signed by dedeta	Part II. Other significant conditions contributing	to death but not resulting	in the underlying cause g	oven in Part I.	23e. Did to	obacco use contr	ibute to the cause of death?
quires quires an sign and be					101	res 2□No	3 Probably 4 QUnknown
I Record The law require page 2 should t					24a. Was autop	osy p	Vere autopsy findings available rior to completion of cause of eath?
Vital Re idician: The hard certificate hard rector, page 18 Comi	25. Was case referred to medical			00.01	1 Tes	2 No 1	☐ Yes 2 No
of Vita hysician: his certific al director.	examiner?  1 Yes 2 No Hospital:	1 Inpatient 2 ER/O	outpatient 3 DOA	26. Place of Deatl ther: 4 □ Nursing Ho		<i>ine)</i> dence 6 ⊟Othe	ar (Snecify)
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ision (the ndir death. Stor: Af	2 Accident investigation 3 Suicide 6 Could not be		M 1[	Yes 2□No			
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Divisio  To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the tu	29a. Certifier (Check only one)  1 Certifying Physician: T 2 Medical Examiner: On and	o the best of my knowledg the basis of examination a manner stated.	ge, death occurred at the nd/or investigation, in my	time, date and place, opinion, death occurr	and due to the ed at the time,	cause(s) and mai date and place, a	nner as stated. and due to the cause(s)
To th within To th	29b. Signature and title of certifier	im		nse number		•	(Month, Day, Year)
1000	and and address of person who completed	ı		5149	57	90032	229 2005 D 21061
U	31. Date filed (Month, (Day, Year)	32. Registrar's Signature	al Wing	- yese	1 1200	rue M	12 21061
State Registrar	NOV 0 2 2005	sz. nogistrai s signature	Arade 3	0			·

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ORIGINAL

				For State Registrar		State of	of Mar	yland		artmen rtificat				Mental Hy	_	2111	) 5	35366
				Decedent's Name (First, M.)	liddle, Las	t)				· · · · · · · · · · · · · · · · · · ·	0 01 1	504.1		2. Date of D	Reg. Neath	10.		3. Time of Death
		Physici			Т	Dominio	· Joh	n C	imaqli	a. Jr				Month Octobe		ay S 2∩i	Year	10:40 A <sup>M</sup>
		/Medi Examir		4a. Facility Name (If not instit				111 0-	ımagıı			r Location	of Death			c. County		
				Upper Chesa	peake	e Hospi	tal			Е	el A	Air				Harfo	ord (	Co.
		Funeral Director		5. Social Security Number 215-07-3449	6. Se			In yrs. la	ast birthday) Yrs.	If Under Months	1 Year Days	If Unde Hours	Min.	8. Date of Bi (Month, D	ау, Үөг			place (State or Foreign intry) land
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		rylan		10a, State 10b. Co	,		1	Oc. City	, Town or Lo	cation								10d. Inside City Limits
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		or 2	Dire	10e, Street and Number						10f. Zip	Code				10g. (	Citizen of \	What Cou	intry?
		death w	rai	2408 Munfor	d Dr							2104				nite		
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	lan	and and seminary		19a. Informant's Name/Relat	ionship (T	ype, Print)								al Route Numb				•
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				shock, or heart failure. Immediate Cause (Final	List only o	ne cause on	each line.	1	,	or the mod	o or ayırı	g, 30011 ac	o da i di de	or rospiratory o	111031,			Interval Between Onset and Death
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0	ital	sician: Th certificate rector, pag	e e	25. Was case referred to med	lical	VVI C						26. Place	e of Deat	1 ☐ Yes	2 🖃 🖍	10	Yes	2 No
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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 5

			State of Ma	ryiand / Depi	rtificate o		•	Reg. No.2	105 3	35261
Physic /Medi	cal	1. Decedent's Name (First, Middle, L.	Davis	. Chr	IRK.	JR.	2. Date of De Month	Day	Year 2005	Time of Death
Examin Funeral Director	ner		Sex 7. Age	(In yrs. last birthday) Yrs.	If Under 1 Yes Months Day	Baltimor ar   If Under 24 Hi	s. 8. Date of Bir n. (Month, Da	B		つのり e State or Foreign
yland how		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. In	side City Limits
ne Mar 8a-fsi	ctor	Maryland Baltimo	re	Bal	timore (	County			1(	□Yes 2⊠No
ath with the 23a or 2	Funeral Director	10e. Street and Number 2423 Cub Hill Rd	•		10f. Zip Code	21234		10g. Citizen of USA	What Country?	
15-0020 72 hours after death with the Marylan "naturel", or items 23a or 28a-f show edical Ever inter reast by notified at	by Fune	11. Marital Status  1 □ Never Married ★ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? MXYes 2 No If Yes, Give Year or Dates: W		Was Decedent o If Yes, specify Cu 1□Yes 🍇 N	f Hispanic Origin? ( uban, Mexican, Pue o <i>Specify:</i>	Specify Yes or No irto Rican, etc.)	14. Rad Bla Specif	ce - American Inc ick, White, etc. v Whit	
d 212. filed withir Hygiene. rther than ent, the Me	e Completed by	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)  11 yrs.  17. Father's Name (First, Middle, Lasi	ade co <i>mpleted)</i> College (1-4or 5+ N/A	•)	dent's Usual Occ kind of work don DO NOT use reti ect Mana		orking ame (First, Middle	Baltimo	Business/Industry  Ore City	Hospita
arylan should be nd Mental marked o	To Be	George D. Clark	, Sr.				Irene E		,	
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: If them 27 is marked any Injury or other traumatic evonce.	1 5	19a. Informant's Name/Relationship	**			et and Number or F				)
re, r 1 and Health Health		Elsie A. Clark 20a. Method of Disposition		2423 20b. Place of Dispondentery, crer		Ll Rd. Ba	ltimore,		234 - City or Town, SI	ate
Pages nent of int: If i	1	XX Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State (y)	Parkwood			10~31~05			
balt permit. Departr Imports any inje		21. Signature of Funeral Service Lice	nsee		. Name and Add	· L	assahn F			
<u> </u>		23a. Part1. Enter the disease, or comshock, or heart failure. List only	waln			air Rd. E		•		
Physician /Medical Examiner	xaminer	Immediate Cause (Final disease or condition resulting in death)	a. Proe	ue to (or as a consequent)	uence of):	annel			Onse	oximate rel Between trand Death
)X <b>C6/CU,</b> certificate be executed ding physician and ise as the burial-transit	√Medicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	ue to (or as a conseq	uence of):					
To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours affect death.  Or the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/	Part II. Other significent conditions of	ontributing to death but	not resulting in the ur	nderlying cause g	given in Part I.	1 🗆 '	res 2 do	ntribute to the ca	4 ☐ Unknowr
law requires bear seconds and seconds are seconds and seconds and seconds and seconds are seconds and seconds and seconds are seconds and seconds and seconds are seconds and seconds and seconds are seconds and seconds and seconds are seconds and seconds are seconds and seconds are seconds and seconds are seconds and seconds are seconds and seconds are seconds and seconds are seconds and seconds are seconds and seconds are seconds and seconds are seconds and seconds are seconds are seconds and seconds are seconds are seconds and seconds are	Completed						24a. Was perfo	an autopsy med?	24b. Were aut available completic of death?	prior to on of cause
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ysicie ysicie is cert	To Be	examiner?	Hospital:	2 ☐ ER/Outpatien	3□ DOA O	ther: 4 Nursing I	ath <i>(Check only o</i> Home 5	ne) ence 6 □Oth	er (Specify)	
To the Hospital or Attending Physicien: The law requires the within 24 hours after death.  With a Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be	Certification:	27. Manner of Death  1 Natural 2 Accident investigation 3 Suicide 6 Could not be determined		/ - At home, farm, stre		Yes 2 □ No	28d. Describe h	treet and Numb	red er or Rural Route	a Number,
ne Hospital c n 24 hours af ne Funeral D pletely filled i	edical Ce	29a. Certifier (Check only one)	ysician: To the best of ininer: On the basis of each manner state	kamination and∕or inv	occurred et the t estigation, in my	ime, dete and place opinion, death occ	e, and due to the curred at the time, c	ause(s) and ma late and place, a	nner as stated. and due to the ca	use(s)
To the within complete the comp	2	29b. Signature and title of certifier	lev	_ wr		nse number 055 C A Raive		-	d (Month, Day, Yo	-
10/2		30. Name and eddress of person who	completed cause of dea	th (Item 23a) (Type, F	Print)	10 Raile	n Ba.	d R	altime	Ve MI
Sta	te	31. Date filed (Month, Day, Year)	32 Registrer's	s Signature	. 69 0	y . 100 V		10		)

DHMH 16 Rev 6/95

	_	•	1 - State Amend Item 5	State of Maryla per informat	14 G829	rtificate of	tas Death			35370
н	Physici		Decedent's Name (First, Middle, Las	t)			3 Mcarl	2. Date of Dea Month	Day Yea	
	/Medic		STELLA				ASON	October	30 200	
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, o	* .	in	4c. County of De	am N/A
	Funeral		THE JOHNS HOPKII		. last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birt	h 9.8	irthplace (State or Foreign
	Funeral Director			ом жог б		Months Days	Hours Min	(Month, Da)	y, Year)	Country) MISSISSIPPI
	P.		Usual Residence of Decedent							
	arylar show	_	10a. State 10b. County	106. 0	ity, Town or Lo		CIMV			10d. Inside City Limits 11 Yes 2 □ No
	the Marylar 28a-f show notified at	ecto	MD N/A		БА	LTIMORE	CITY		10g. Citizen of What (	
	with t	Funeral Director	10e. Street and Number 5422 PRICE AV	FNIE		10f. Zip Code	215		USA	Sourity :
	leath w	era	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of H		Specify Yes or No-		nerican Indian,
ω.	after or iter	ᇳ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 💆 No				rto Rican, etc.)		
5-0036	i 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show cifed Examiner must be notified at	by	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 🌠 No	Specity:		Specify:	BLACK
		Completed	15. Decedent's Ed (Specify only highest gra	ucation de <i>completed)</i>	16a. Dece (Give	during most of wo	orking	16b. Kind of Busines	ss/Industry	
121		dm	Elementary/Secondary (0-12)	College (1-4or 5+)	STANT		MEDIO	<b>7</b> ΔΤ.		
CA	filed Hygie thar int.		1.2 TH 17. Father's Name (First, Middle, Last)			me (First, Middle,	Maiden Sumame)	ZAL		
an	should be filed within nd Mental Hygiene. marked othar than imatic evant, It u M.	To Be	JOSEPH EI	LLIS		WILLIE	B. JOHNS	SON		
Maryland	- m -	-	19a. Informant's Name/Relationship (7	урө, Print)	and Number or F	lural Route Numbe	er, City or Town, State	, Zip Code)		
Ž	1 and 2 Health a am 27 Is		TERRY M. CASON	1/DAUGHTER	_617	LUCIA	AVENUE.	BALTII	MORE, MD	21229
ore,		15	20a. Method of Disposition	20b.	Place of Dispo	osition (Name of matory or other place	ce)	Date	20c. Location - City	or Town, State
Ë	Page nent o ant: If ury or		1 X Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify		RBUTUS	MEM. P	$K. \mid 11/$	05/05	BALTIMOR	RE CO., MD
Baltimore	permit. Page Department o Important: If any injury or once.		21. Signature of Juneral Service Licen	See A. A. A.	3	2. Name and Addre				HOME 21207 LTIMORE, MD
	100		23a. Bay En ir the disease, or comp	olications that caused the decone cause on each line.	Do not en	ter the mode of dyin	ng, such as cardia	c or respiratory ar	rest,	Approximate Interval Between
	Pnysician	8 0	Immediat _ause (Final diseas or condition	Pulmona	ru es	mboli				Onset and Death
	/Medical		resulting in death)	Due to (or as a conse	equence of):					2
	Examiner		Sequentially list conditions	. Metastat	10 E1	ndomet	vial (	ancer		3 months
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	be execut iclan and burial-trar	Examin	that initiated events resulting in death) Last	c. Due to (or as a conse		Carre				INOMNZ
8760	cate be executed obysician and the burial-transit	dical E		d						
9	ertificate ing phys e as the	ledi								
Вох	0 2 3	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		☐Ectopic pregnancy	,		23d. Date of c	•
	the atter	sicie	in the past 12 months?	4☐Pregnant at time of 9☐Unknown		Other (specify)			Month	Day Year
P.0	± > ○	Phy	9 Unknown  Part II. Other significant conditions c		aultina in the .	and ask in a name of the	on in Dod I	220 Didte	phago uso postributo	to the cause of death?
Vital Records,	es ign	by	Part II. Other significant conditions (	onthouting to death out not re		anderlying cause giv	enin raiti.			Probably 4 Sunknown
00	2 0 10	Completed						24a. Was	an 24b. Were	autopsy findings available
R	0 = 0	E							rmed? death	o completion of cause
ita	iclan: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?				26. Place of De	ath (Check only o		
of V	S S	2	1 Yes 2 No	Hospital: 1 Impatient 2	☐ ER/Outpatie	nt 3□ DOA Oth	er: 4 ☐ Nursing	Home 5 Resid	dence 6 □Other (Sp	pecify)
n o	ding Ph .r After th funeral	on:	27. Man of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	rk?	28d. Describe h	now injury occurred	
sio	tendi leath. tor: A	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No	206 Leasting /6	Street and Mumber or	Dura I Paula Mumbas
Division	al or Attending I safter death. I Diractor: After d in by the funer	Certification;	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	nome, tarm, st cify)	reet, factory, office		City or Tox	Street and Number or vn, State)	Hurar Houle Number,
J	To tha Hospital or Attens within 24 hours after death To tha Funaral Director: completely filled in by the	edical Ce	(Check only 2 Medical Exan	ysician: To the best of my k niner: On the basis of exami						
	To tha within 2 To tha complet	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Date signed (Mo	nth, Day, Year)
	F 3 F 8		/ LA IA				-000			
	in	/	30. Name and address of part on who	completed cause of death /lt.	em 23a) (Tune		- 111.		Ctoher 3	
1	5		Wolanda Henrila	Y THE TOHNS	HOPKIN	IS ITOSPITTA	L. GODNI	WH WOLFE	STREET DA	21287 LTI MORE MARYLAND
7	Sta	ite	3. Date filed (Month, Day, Year)	00.49			1			
	Regist	harris of other lands and the second								

		1	For State Registrar	State of N	Maryland		artment of H		and Men		ene 20	05	35371
			Decedent's Name (First, Middle, I	Last)	<del>-</del>					Date of Death			3. Time of Death
	Physici /Medic		Mary Hildegr	ad Currens					1 -	tober	30 2	Year 2005	12:00A. <sup>M</sup>
	Examin		4a. Facility Name (If not institution, g	rive street and number	or)		4b. City, Town, or	Location o	of Death		4c. County	of Death	
			Mayfield House				Catonsv				Balt	imor	e
	Funeral		5. Social Security Number 6. 577-07-4737	. Sex 7. A 1 □ M 2 🖺 F	Age (In yrs. Ia: 90	st birthday) Yrs.	If Under 1 Year Months Days	Hours 1	Min (	Date of Birth Month, Day,	(ear)	Cour	place (State or Foreign htry)
	Director		Usuel Residence of Decedent		90				Se	pt. 16	,1915	Penn	sylvania
	yland		10a. State 10b. County		10c. City,	Town or Lo	cation					1	0d. Inside City Limits
	a-f-a	ctor	Maryland Baltim	iore	C	Catons	ville						1 ☐ Yes 2 🖾 No
	ii th	Director	10e. Street and Number			_	10f. Zip Code			10	g. Citizen of \	What Cour	ntry?
	ath w	Funeral	123 Fairfield 1				21228				U.S.		
	item item	une	11. Marital Status	12. Was Deceder	s?		Vas Decedent of Hi f Yes, specify Cubar	spanic Orig n, Mexican,	gin? (Specify i, Puerto Ricai	Yes or No- n, etc.)		e - Americ ck, White,	
36	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Dates			I□Yes 2XINo	Specify:			Specify	" Whi	t o
ğ	filed within 72 hours after death with the Maryland Hygiene. Sther than "naturel", or Iteme 23a or 28a-f ehow ent, tra Medical Exactinar minite notified at	ted	15. Decedent's	Education		16a. Deced	lent's Usual Occupa	ition		16	Bb. Kind of B		
2	thin 7	Completed	(Specify only highest of Elementary/Secondary (0-12)	College (1-40	or 5+)	life. I	kind of work done d OO NOT use retired,	u <i>ri</i> ng most )	or working				
7	ed wi	Co	12			Sec	retary				Bank		
Maryland 21215-0036	₩ a b ≥	Be	17. Father's Name (First, Middle, La.  James Muldoon	st)						st, Middle, Ma	uiden Suman	10)	
Ĕ	2 should be filed within 72 hours after death with the Marylan and Memlat Hygiene a land Memlat Hygiene is marked other than "naturelt, or liteme 28a or 28a-1 show raumatic event, it a Medical Examinat mast be notified at	၉	19a. Informant's Name/Relationship	(Type Print)		10h Madin	g Address (Street a		nna Br		City of Town	Ctata Zin	Codel
<u>8</u>	id 2 s Ith an 27 is: traus			aughter)			Crosby Roa			ille,			
	s 1 and / Heelth item 27 other to		20a. Method of Disposition	<u>ragireer</u>	20b. Pia		sition (Name of natory or other place		Date		C. Location -		
Ë	Pages nent of I ant: If it		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		10		Cemetery		1-2-20	05 Ma	arriot	tsvi1	le, MD
Baltimore,	1 2 2 2		21. Signature of Funeral Service Lic			22	. Name and Addres	s of Facility	v				
<u> </u>	Den Per Per Per Per Per Per Per Per Per Per		Intel /2	40)	_	16	tzke Fune 30 Edmone	dson A	Avenue	Cato	nsvill nsvill	e, In e, MI	1c. 21228
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	implications that caus	ed the death.								Approximate Interval Between
Z	nysician		Immediate Cause (Final disease or condition	. Cei	rebro	Vas	cular	AC	ced	ent			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	as a conseque	1	-1- 1						42
	7.	<u>.</u>	Sequentially list conditions,	0	eVCO5		rolle ne	carl	de-	seas	P	-	40 40
	uted I Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Eliza	porto	11000	Circos	scal.	(a)-			- 1	1000
Č.	be executed sicien and burial-transit		that initiated events resulting in death) Last	C. Due to total	as a conseque	nce of):	Com						7.
8760,	death certificate be executed e attending physicien and ed for use as the burial-transit	dicai	•	d									
39	artifica ing ph e as ti	Med	IF FEMALE:										
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?		2 ☐ Fetal d	leath 3	Ectopic pregnancy				23d. Dat Mo	te of delive	ry Day Year
0	res that the de igned by the a be detached f	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Pregnant 9□ Unknown	at time of dea	ith 5□	Other (specify)		<del></del>				Day Toal
α.	requires that the	Ph	Part II. Other significant conditions	s contributing to death	but not result	ting in the ur	iderlying cause give	n in Part I.		23e. Did toba	cco use cont	ribute to th	e cause of death?
Division of Vital Records,	lurres sign lid be	d by	Alzhe	eimers	Dis	easi	2_			1 ☐ Yes	2 No	3 🔲 Prob	ably 4 Unknown
Ö	> 11 0	lete	Demo	entia						24a. Was an	24b. \	Nere autor	osy findings available
æ	0 5 0	Completed								autopsy performe	d?	prior to cor death?	npletion of cause of 2□ No
ta	ician: Th certificete rector, pag	BeC	25. Was case referred to medical					26. Place	of Death (Ch		3No 1	105	2 10
<u>~</u>	G is X	2	examiner? 1 ☐ Yes 2 █Wo	itient 2□El	r: 4 □ Nur	rsing Home	5 ☐ Residen	ce 6 00th	er (Specify	Assisted Living			
ב ס	Attending Physician: r death. sctor: After this certific by the funeral director.		27. Manner of Death  1) ✓ Natural 5 ☐ Pending	28a. Date of In (Month, D	njury 2 Day Year) 2	8b. Time of Injury	Work			Describe how	injury occurr	ed	
<u>s</u>	ttend death tor: A	cat	2 Accident investigat 3 Suicide 6 Could not	he				′es 2 □ N					
<u>&gt;</u>	or A after Direction by	Certification:	4 ☐ Homicide determine	building,	etc. (Specify)	ne, tarm, str	et, factory, office		281. [	City or Town,	et and Numb State)	er or Rura	l Route Number,
	spital lours nerai filled		29a. Certifier 1 Certifying I	Physician: To the bes	st of my knowl	ledge, death	occurred at the tim	e. date and	d place, and d	fue to the cau	se(s) and ma	nner as st	ated
	To the Hospital or Attending Phyminin 24 hours attended the Tothe Funeral Director: After the completely filled in by the funeral	Medical	(Check only 2 ☐ Medical Exone)	aminer: On the basis and manner	of examinatio	on and/or inv	estigation, in my op	inion, deat	h occurred at	the time, date	and place,	and due to	the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier	100:			29c. License	number		290	. Date signed	(Month,	Day, Year)
)	^		Koberle	Mora	e 7	no	0	567	246		10/3	1/0-	5
	,7		30. Name and address of person wh	no completed cause of	f death (Item 2	(Type,	Print) Rd (	-	2.		17	100	
	-0-		31. Date filed (Month, Day, Year)	39 Ranie	strar's Signatur	oesle	v Kd (	31eu	BUFA	ue 14	iv 2	~06	0
	Sta Registr		NOV 9 2 2U	UU DE LA	strar's Signatu	1500	de						

		•	For State Registrar	State of	Marylan	•	artmen rtificat			and M	lental Hyg	giene Reg. No:	05	35372
			Decedent's Name (First, Middle, L.	ast)							2. Date of Dea	ath	Vasa	3. Time of Death
я	Physicia /Medic		Grace Jackson Co	rnish							Month October	29, 20	Year NS	5:50 p M
	Examin		4a. Facility Name (If not institution, g.	ve street and numb	oer)		4b. City,	Town, or	Location o	of Death		,	unty of Death	7.3.30 P
п			Manor Care Nursing	Home				Towso	n				Baltimor	re
	Funeral Director		5. Social Security Number 6. 214-22-1300	Sex 7. 1 ☐ M 2 🔀 F	Age (In yrs.		If Under Months	1 Year Days	If Under a Hours	Min.	8. Date of Birt (Month, Da	y, Year)	9. Birthi Cou Virgi	place (State or Foreign ntry) LN1A
	pu News		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	cation		-					10d. Inside City Limits
	anyla shov	-			100. 01	•								1K Yes 2 □ No
	Ne M	ecto	MD NA			E	Saltimo					10- 0%		
	with 1	급	100. Street and Number				10f. Zip	2121	7			rog. Citizer	of What Cou	nuyr
	eath	eral	1200 W. Lafayette Ave	12. Was Deced	ent Ever in II	S 13 V	Mas Decer			nin? (Sne	oify Yes or No	14	Race - Americ	can Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "neturel; or items 23e or 28e-f show any injury or other treumstic event, Ite Medical Examinating in item by multibut at once.	by Funeral Director	1 Never Married 2 Married  3X Widowed 4 Divorced	Armed Force 1 Tes 2 If Yes, Give Year or Date	es? M≀No		f Yes, spec		Specify:	i, Puerto	ecify Yes or No- Rican, etc.)	}	Black, White,	etc.
21215-0036	2 hou	pe	15. Decedent's	Education		16a. Deced	dent's Usua	I Occupa	ation			16b. Kind	of Business/In	
5	nin 72 n "n	Completed	(Specify only highest g	rade completed) College (1-4	lor 5+)	(Give	kind of wo DO NOT us	rk done d se retired,	luring most }	t of worki	ng			·
2	d with	mo.	8	College (1-4	101 3+)	Cus	todian	l					Governme	ent
ğ	a filec Il Hyg othe /ent,	Be C	17. Father's Name (First, Middle, Las	t)					18. Mothe	r's Name	(First, Middle,	Maiden Sui	mame)	
<u>a</u>	Ald by Alenta	To E	Henry Turner							Anna	Thomas			
Maryland	should be should	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	ng Address	(Street a	and Numbe	r or Rura	l Route Numbe	or, City or To	own, State, Zip	Code)
Σ	and 2 alth a	1	Elaine Morton/ Daug	hter		120	0 W. L	afaye	tte Av	enue	Balto,M	D 21217	,	
J.	of He of He item		20a. Method of Disposition	CB		Place of Dispo	sition (Nar.	ne of ther place	9)	- 0	ate	20c. Locat	ion - City or To	own, State
Ĕ	Page nent on int: If		1 XBurial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spec		Ba1	timore N	lationa	1 Cem	etery	11-2-	05	Balti:	more, M	)
Baltimore,	permit. Departn Importe any inju		21. Signature of Funeral Service Lic	Opres	$\supset$		Name an Mylie F			•	N. Gilmo:	r St. B	alto, M	21217
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cau	used the deat	h. Do not ent	er the mod	e of dying	g, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between
	Enysician <sub>1</sub>		Immediate Cause (Final			KI	SALCI	U.	0155	AL	۶			Onset and Death
	/Medical		disease or condition resulting in death)		as a conseq		שאונ	7	V   > C	(1 > )	L			
ı	Examiner			To	492	TL	DIAB	JE :	s m	ELL	ITUS			
	120 00	je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	D. Lua to (or	pasnos a sa									
	cuted id ansit	Examin	Cause (Disease or injury that initiated events	C.										
ó	an ar rial-tı	EX	resulting in death) Last	Due to (or	r as a conseq	uence of):								
8760,	icate be executed physician and s the burial-transit	dlcal		d										
9	ntifica ng ph s as th	Med	IF FEMALE:											
Вох	The law requires that the death certificate has been signed by the attending lange 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	ome of pregna h 2 Feta		Ectopic pr	egnancy				23d.	Date of deliver	ery Day Year
E	e dea the at	sici	1 Yes 2 No	4□Pregnar 9□Unknow	nt at time of d m	leath 5□	Other (sp	ecify)					WORT	Day 10ai
Ρ.	d by etact	Phy			4h h.u. == 1 == 1	udale er ier als er un			- in Danil		030 Did to			he saves of dooth?
	res tha igned be det	by	Part II. Other significant conditions  MYPERTER	_	un par nor res	ulling in the ul	nderlying c	ause give	m in Fan I.			os 2□N		he cause of death?
Vital Records,	v requir been si should	ompleted	11/18/10	421010								65 Z N	0 3   100	Sabiy 4 DOTKHOWN
ec	ne law has b ge 2 st	ple									24a. Was autop	sv	prior to co	ppsy findings available impletion of cause of
<b>B</b>		Con										med? 200 No	death? 1 🗌 Yes	2 🗆 No
ita	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?							of Death	(Check only o	ne)		
of \	d is	2	1 ☐ Yes 2 No		ER/Outpatien		)A Othe	PSNu	77	ne 5□ Resid			(y)	
lon c	ding After funer	atlon:	27. Manner of Death  1. SNatural 5 Pending 2 Accident investigati	on	Injury Day Year)	28b. Time of Injury	M 2	8c. Injury Work 1 🔲 Y	at ? /es 2 🗆 1		28d. Describe h	ow injury od	curred	
Division	el or Attencs after death	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 286. Place o	f Injury - At ho g, etc. (Specif	ome, farm, str (y)	eet, factory	, office		2	28f. Location (S City or Tow	Street and N m, State)	umber or Rura	al Route Number,
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical (	29a. Certifier jD-Certifying I (Check only one)	Physician: To the bas aminer: On the bas and manne	is of examina	wledge, death tion and/or inv	occurred vestigation	at the tim , in my op	e, date and pinion, deal	d place, a	and due to the ded at the time, d	cause(s) and date and pla	d manner as s ice, and due to	stated. o the cause(s)
	To the I within 2 To the I complet	M	29b. Signature and title of certifier				290	. License	number			29d. Date si	igned (Month,	Day, Year)
	0/	MA A	1	0005	5910=	7		11-0	11-2	505				
1	11		30. Name and address of person wh	o completed cause			Print)	_		B .	LTIMOR			. ,
5	)		KALU UMA	2600 4	BERT	y nerly	17/5	AVEN	148	5A	LTIMOR	E mg	) 2/2	15
	Sta	te	Control Contro											
	Registr	ar	110 4 4	-	See See American	-								

For Amend Item 18&20c per fh 6849 Department of Health and Mental Hygiene 15 Certificate of Death Reg. No. 35373 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death OCTOBER 30, 2005 **Physician** CHECKET 1:20 A Μ. PIERSON /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CARROLL WESTMINSTER 1316 SAINT HALES COURT If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 00 40 10 3 1976 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1**∑**M 2□F 89 MD Yrs 001-18-1201 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director WESTMINSTER CARROLL 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ō USA 1316 SAINT HALES COURT 21158 238 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 00 Yes 2 □ No WWII If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2() Married Baftimore, Maryland 21215-0036 ö 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natursl', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) The Medical 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) MEDICINE **SURGEON** 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental h - BLITCHER CHECKET BENJAMIN Ρ. EDITH Butcher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2: Department of Health at Importent: if Item 27 is any Injury or other trau once. 1316 SAINT HALES COURT - WESTMINSTER, MD 21158 BEATRICE CHECKET WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
Reisterstown
WESTMINSTER, MD 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State OHEB SHALOM MEMORIAL 11/01/2005 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn failed. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Gause (Final disease or condition resulting in death) SNDSTAGE KENAL **Physician** /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner resulting in death) Last Due to (or as a consequence of) ed by the attending physician adetached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown cete has been signed by t page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an this certificate has 2**X** No 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient ≥X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? After Natural Accident Injury 5 Pending 1 Yes investigation the Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause (Item 23a) (Type, Print) Stref/BoltoMD . Charles 32. Apristrar's Signature Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydienes or

			1- State Amend Item 1,10e,18,19b I	per phy&i	tificate of	dealth and Men LI-7-05 tas Death	Ital Hygier	005	35374
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Mary E. Caute	Mary l	Ellen Ca	rter	Date of Death Month C C to be	28 200	3. Time of Death 5 12:55 pm
	Examir	er	4a. Facility Name (If not institution, give street and number) Howard County General H	ospital		r Location of Death	4	c. County of Deat	Λ
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In y 2 7 F 64	vrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min. (	Date of Birth Month, Day, Yea $pt. 21$ ,	9. Birt 20 1941 Mai	hplace (State or Foreign unity) cyland
	yland how			City, Town or Loc	cation				10d. Inside City Limits
	Ba-fs	Director		llicott	-, - <u>-</u>				1 ☐ Yes 2√☐ No
	with the		10e. Street and Number  Doncaster  4618 Duncaster  Drive		10f. Zip Code 21043	1	10g. C	itizen of What Co U.S.A.	untry?
٥	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Integrational of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Ever, it at most be inclined at once.	Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  1 Never Married 2 Married  1 Yes, Give	If	Vas Decedent of F Yes, specify Cub	lispanic Origin? (Specify an, Mexican, Puerto Rica	Yes or No- n, etc.)	14. Race - Ame Black, White	rican Indian, a, etc.
200	ural', c	d by	3 Widowed 4 Divorced Year or Dates:	1	☐ Yes 2 No	Specify:		Specify: Wh	nite
6	in 72 t	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occup kind of work done OO NOT use retire	durina most of working	16b.	Kind of Business/	Industry
21215-0036	led with tyglene. har than	Com	Elementary/Secondary (0-12) College (1-4or 5+)	Homema	aker		Ov	vn Home	
Maryland	be filed htal Hygi ad othar evant, I	Be	17. Father's Name (First, Middle, Last)			18 Mother's Name (Fir Madeline Madelina	st, Middle, Maide	n Sumame)	
II yıc	should nd Mer marke	2	Thomas L. Bush  19a. Informant's Name/Relationship (Type, Print)	19h Mailin	n Address (Street				Fin Code)
<u>2</u>	1 and 2 sho Health and lam 27 Is m		William H. Carter, Jrhusband			and Number or Rural Ro. er er Dr., Elli			
ນ໌ ວັ	es 1 a of He of He if itam or oths		20a. Method of Disposition 20b 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	b. Place of Dispos cemetery, crem	sition (Name of natory or other place	Date (	20c.	Location - City or	Town, State
altimore,	t. Pag rtment rtant: I		`4 □Donation 5 □Other (Specify) St			. Ch.10/31/		kridje,	
ם מ	permit, Pages 1 an Department of Heali Important: If itam 2 any injury or othar once.		21. Signature of Funeral Service Licensee	22. G	Sary L. K 7250 Wash	ss of Facility Laufman Fune Lington Blvd	ral Home	e at MMP, Ldge, MD	INC. 21075
	tificate be executed  Wedical  Wedical  Wedical  Wedical  Wedical  Wedical  Wedical  Wedical  Wedical  Wedical  Wedical  Wedical  Wedical  Wedical  Wedical  Wedical	edical Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a constitution).  Due to (or as a constitution).	gestin	umn	monary may hy, art gail	disea norteu. lure	u	Interval Between Onset and Death
- C. DOA	The law requires that the death certif tte has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown   9   Unknown	etal death 3 1	Ectopic pregnancy Other (specify)	,		23d. Date of deli Month	very Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not of the state of the significant conditions contributing to death but not of the significant conditions contributing to death but not of the significant conditions contributing to death but not of the significant conditions contributing to death but not of the significant conditions contributing to death but not of the significant conditions contributing to death but not of the significant conditions contributing to death but not of the significant conditions contributing to death but not of the significant conditions contributing to death but not of the significant conditions contributing to death but not of the significant conditions contributing to death but not of the significant conditions contributing to death but not of the significant conditions condi		derlying cause giv	en in Part I.		A 4	the cause of death?
VIIAI DECOIUS,	. The law requ cate has been page 2 should	Completed					24a. Was an autopsy performed?	prior to c death?	copsy findings available completion of cause of
V 110	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?		3□ DOA Oth	26. Place of Death (Ch.			
5	ding Phys n. After this funeral di	H- 1	1 Yes 2 No Pospital 1 Inpatient 2  27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur	y at 28d. I	5 Residence Describe how inju		ify)
DIVISION	or Attane ifter death Diractor: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - Al building, etc. (Spe	t home, farm, stre		Yes 2 □ No 28f. L	ocation (Street a Dity or Town, Stat	nd Number or Rul e)	ral Route Number,
	To the Hospital within 24 hours a To the Funeral t completely filled	ledical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my k 2 Medical Examiner: On the basis of examinand manner stated.	nowledge, death	occurred at the tin estigation, in my o	ne, date and place, and d pinion, death occurred at	ue to the cause(: the time, date ar	s) and manner as ad place, and due	stated. to the cause(s)
	To ti Withii To tt	Me	29b. Signature and title of certifier		29c. Licens	number	29d. D	ate signed (Month	, Day, Year)
	N	>	of the		DS	08 10	Oct	oser 2	81"2005
2	0		(Check only one)  2 Medical Examiner: On the basis of examinand manner stated.  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (II Suzan Alado 5005 Signature).  31. Date filed (Month, Day, Year)  NOV 0 2 2005	nal Be	ell Car	e, Clark	issille	MD	21029
	Sta Registr		31. Date filed (Month, Day, Year) 0 2 2005	inature	franks)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registre Reg. No. U Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 10-26-05 **Physician**  $\mathbf{P}^{\mathsf{M}}$ 2:02 Verla B. Crocetti /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Catonsville

If Under 24 Hrs. 8. Date of Birth
(Month, Day) Baltimore Summit Park Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Numbe **Funeral** Months 1 □ M 2 F 217-22-5564 12/02/1922 Alabama Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 28a-f show la beilifer at tau 1 ☐ Yes 2 ☐ No Director MD Baltimore Woodlawn 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ Items 23a 21207 USA 8100 Dogwood Road Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc permit. Pages 1 and 2 should be itled within 72 hours after d Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Item any injury or other treumatic event, the Mudical Examinations. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: White 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James M. Lackey Ruby J. Freeman 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Thomas Lloyd, Sr / 8100 Dogwood RD. Woodlawn, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State Meadowridge Cemetery 10/29/05 4 ☐ Donation 5 ☐ Other (Specify) Elkride, MD 22. Name and Address of Facility
Kaufman Funeral Home at Meadowridge Mem. Park, IN. Funeral Service Licensee 7250 Washington Blvd., Elkridge, MD 21075 M01378 Approximate Interval Between Onset and Peath 23a Part1. Enter the disease, shock, or heart failure. pleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical **Examiner** 0 Due to (or as a conseque Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury nce of Examiner attending physician and for use as the buriat-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death Year in the past 12 months? 1 ☐ Yes 2 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No 1 Yes 25 26. Place of Death (Check only one) in by the funeral director, 25. Was case referred to medical examiner? Be Other: 4 Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ursing Home 5 Residence 6 Other (Specify) 2 28c. Injury at Work? Mann of Death 28d. Describe how injury occurred 28b. Time of Certification: al or Attending F after death. | Director: After Injury 5 Pending 1 Natural 1 Tes 2 II No investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier

Registrar

State

pleted cause of death (Ite 23a) (Type, Print)

Vibuer

32. Registrar's Signature

2005

and address of person who co

31. Date filed (Month, Day)

w

Year)

		•	For State Registrar	State of M	laryland	d / Depa <i>Cei</i>	artmen rtificate	t of H	ealth a Death	and M		giene Reg. No.	00	5	353	76
			1. Decedent's Name (First, Middle, Las	st)	_						2. Date of De Month	ath Day	Y	ear	3. Time of	Death
	Physici /Medio		JENNIFER LYNN DO	YLE							Octobe	r 27	, 200	5	9:00	P M
	Examir		4a. Facility Name (If not institution, give	street and number	)		4b. City,	Town, or	Location o	f Death		4c.	County of	Death		
		۳.	3919 North Point	Blvd.			Dun	dalk				В	altim	ore		
	Funeral		Social Security Number     6. S	DA SELE	ge (In yrs. ia		If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Bir (Month, Da	v. Year)	9	Birthpl Coun	ace (State o	r Foreign
11.	Director		210-92-2432	□M 2只F	27	Yrs.		,			10-12-	1978	M	ary	land	
	p s		Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	cation							1/	Od. Inside Ci	tv Limits
	sho	5												"	1 🗆 Yes	
	Ne N	ect	Maryland Baltimo	re	1	undal		Code				10- 04	zen of Wha	A C = 1 = 1	10.2	
	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show Jical Evaniner must be redilled at	Funeral Director	3919 North Point	D1***			10f. Zip	222							•	
	s 23	era		12. Was Deceden	Ever in 11 S	12.1			annaia Orie	ain? /Sna			ed St			
	er de Itam Derr	un.	11. Marital Status  1 □ Never Married 2 Married	Armed Forces	?	).   13. Y	f Yes, spec	ify Cuba	n, Mexican	, Puerto	cify Yes or No Rican, etc.)		Black,			
36	rs aft	by F	3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		1	1 ☐ Yes 2	No 🏡	Specify:				Specify:	Wh	ite	
21215-0036	hou	ed	15. Decedent's Ed			16a. Deced	dent's Usua	I Occupa	ition			16h Kir	nd of Busin			
5	in 72 in 72 in 16	Completed	(Specify only highest gra	de completed)	- )	(Give life. l	kind of wor DO NOT us	k done d e retired,	luring most )	of worki	ng					
12	with tha	lmo	Elementary/Secondary (0-12)	College (1-4or 1 year	5+)	Medic						Неа	lthca	re		
p	filed Hyg otha	Be C	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)			
<u>a</u>	id be ental ked ic av	To B	Larry P. Stahl						Datri	icia	K. Edm	inat	on			
Maryland	d 2 should be th and Menta 7 Is marked traumatic av	-	19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	ng Address				I Route Number			te, Zip	Code)	
Ž	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hyglene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic avant, the Medical Esaminer must be notified at		Larry P. Stahl (F	ather)		302 B	arcla	v Co	urt	7	Abingdo	n . M	arvla	nd '	21009	
ē,	Hear Harm Starm othe		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Nan	ne of			ate		cation - Cit			
5	age ant o M: If i		1 ⊠Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specification)							LO <b>-</b> 31	-2005	Balt	imore	, Ma	arvlan	d
Baltimore,	permit. Pages Department of Important: If ii any injury or o		21. Signature of Funeral Service Licer	<u> </u>							Home of					
Ba	permi Depa Impo any ir		Much all													
			21. Part1. Enter the disease, or com shock, or heart fall rie. List only	plications that cause	d the death.						ndalk, r respiratory a		yrand	21.	Approximate	э
			shock, or heart fallere. List only Immediate Cause (Final			,		4							Interval Bet Onset and I	Death
	Physician /Medical		disease or condition resulting in death)	a A c u			· (ce	Mig						-	mont	ns
	Examiner			Due to (or a	s a consequ	ence or):										
	HARR	P.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	s a conseque	ence of):								_		-
	ted nsit	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury													J.
	certificate be executed iding physician and ise as the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or a:	s a conseque	ence of):										
8760,	siciar buri	al		d												
687	ficate phy: s the	Physician/Medical	`	d												
Вох	eath certific attending p	/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom-								2	3d. Date o	f delive	rv	
m	death e atter	clai	in the past 12 months?	1□Live birth 4□Pregnant a			]Ectopic pr ] Other (sp						Month		Day Y	ear ear
P.O.	the y th	Jys	9 Unknown	9□ Unknown								- 1				
	requires that een signed b rould be deta	by Pi	Part II. Other significant conditions of	ontributing to death	but not resul	lting in the u	nderlying ca	ause give	n in Part I.		23e. Did t	obacco u	se contribu	te to th	e cause of d	eath?
ds	puires n sign	d D									1 🗆 '	res 2	3 No 3	] Proba	abiy 4 🗆 U	inknown
00	> 9 10	Completed									24a. Was	an	24b. Wer	e autor	sy findings a	available
Re	The law cate has b page 2 sl	m									autor perfo	rmed?	prio dea	r to con th?	npletion of ca	luse of
a	iclan; Th certificate rector, pag		25. Was case referred to medical						00 71	( D	1 Yes		1 🗆	Yes	2 No	
₹		Be c	examiner?	Hospital:	2 T	2/0-1		Othe			(Check only o					
Division of Vital Records,		: To	27, Manner of Death		ient 2 🗆 E	28b. Time of		8c. Injury	4 🔲 Nu	_	ne 5 🔀 Resid			Specify	)	
D.	ding Ph h. After th funeral	tlor	1. Anatural 5 ☐ Pending investigation	28a. Date of Inj (Month, D	ay Year)	Injury	М	Work								
S	deat ctor: y the	lica	3 Suicide 6 Could not b		niury - At hor	ne, farm str				-	28f. Location (	Street and	d Number o	or Rural	Route Numi	ber.
Ö	after Dira	Certification:	4 ☐ Homicide determined	building, e	itc. (Specify)	)	001, 1001019	, 011100			City or Tov					,
_	To the Hospital or Attending within 24 hours after death.  To the Funeral Diractor: After completely filled in by the fune	C	29a. Certifier 1  Certifying Ph	ysician: To the bes	t of my know	rledge, death	occurred:	at the tim	e, date and	d place. 2	and due to the	cause(s)	and manne	er as sta	ated.	
	24 h 24 h Fur etely	edical		niner: On the basis and manner s	of examinati											ļ
	o the	Me	29b. Signature and title of certifier				290	. License	number			29d. Date	e signed (A	fonth, [	Day, Year)	
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,	> >		30. Name and address of person who	4.4	death (Item	23a) (Type		. , 7	' ' '	84H			an C	1		
5	18		life Oller	CL. +	D 1		M	۱ س ب	land							
1	Sta	te	31. Date filed (Month, Day, Year)	32. Regis	trar's Signati	Re V	rested	7								
	Regist		31. Date filed (Month, Day, Year)	005	Allens of	A PROPERTY	N. W.									

				1 - For State Registrar	State of Ma	aryland	l / Depa <i>Cer</i>	irtment tificate	t of H	eaith and M Death		gienne	05	35377
				Decedent's Name (First, Middle, La	ast)						2. Date of De	ath	Vana	3. Time of Death
		Physicia /Medic		Cassandra	С.			Da	vis		Month 10	28	O5	6:24P.M
		Examin		4a. Facility Name (If not institution, gir						Location of Death		4c. Cour	nty of Death	
				Joseph Richey						more			_	
		Funeral			Sex 7. Age 1 ☐ M 2X☐ F		st birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y, Year)	9. Birthp Cour	place (State or Foreign htry)
		Director		212-60-7114 Usual Residence of Decedent		54	115.				12 0	6 50		MD
		land ow		10a. State 10b. County		10c. City,	Town or Lo	cation					1	Od. Inside City Limits
		Mary -1 sh	to	MD NA		Ba	ltimo	re						1 XYes 2 □ No
		r 28a	rec	10e. Street and Number				10f. Zip	Code			10g. Citizen o	of What Cour	ntry?
		death with the Maryland ms 23a or 28a-f show rrivet be rivilled at	0	2029 Wheeler A	ve				21.	216		U	.S.A.	1965
		deat	<b>Funeral Director</b>	11. Marital Status	12. Was Decedent 8 Armed Forces?	er in U.S	i. 13. V	Vas Deced	ent of His	spanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No	14. P	ace - Americ	
	9	e filed within 72 hours after dea al Hygiene. other than "natural", or Items vent, the Medical Examinar na	正	1 Never Married 2 Married	1 Tes 2 X	lo		Yes 2		Specify:	nioan, otc.,	Spec		
	933	Jral',	d by	3 Widowed 4 Divorced	Year or Dates:							Sper	B1	.ack
	5	nat nat	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Deced	lent's Usua kind of wor	k done d	tion uring most of workin	ng	16b. Kind of	Business/In	dustry
	121	withir ane. than	mp	Elementary/Secondary (0-12)	College (1-4or 5	+)		ial				Balto	Cit	y Schools
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	an	d be ental ced o	To Be	James H. Davis						Geraldin				
	Maryland 21215-0036	shoul nd Me mark	Ĕ	19a. Informant's Name/Relationship			19b. Mailin	g Address		nd Number or Rura			m, State, Zip	Code)
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	ē,			20a. Method of Disposition		20b. Pla	ace of Dispos metery, cren	sition (Nam	ne of	D	ate	20c. Location	n - City or To	own, State
0	9	Pages nent of int: If II		1   Burial 2 □ Cremation 3   Cremation 3 □ Other (Special Control Con		Ki				" Bark 11,	/3/05	Randa	llsto	wn. md
3.6	Baltimore,	그는만등		21. Signature of Funeral Service Lice		1 1(1)	22	. Name and	d Addres	s of Facility				, will, illia
31	Ö	Depa Depa Impo any ir		> Den	D9Ke	E.	M	355h	wE6	H West ash Ave,	Balt	imore	, Mđ	21215
13				23a. Part1 Enter the disease, or con shoot or heart failure. List only	nplications that caused	the death.	Do not ente	r the mode	e of dying	, such as cardiac o	r respiratory a	rrest,	,	Approximate Interval Between
		Physician		Immediate Lause (Final disease or condition	Navisa	42//	11/	luns	1 12	WAV	11/1/4	mos	13	Onset and Death
		/Medical		resulting in death)	a. Due to (or as	a conseque	ence of):	4119	U.	nces 4	VIIII.	III		4/1
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12		D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):							
20		and trans	tam	Cause (Disease or injury that initiated events resulting in death) Last	C.									
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1		= O 4		IF FEMALE:	23c. If yes, outcome	of pregnan	cv					004.5	Data of daling	
	Вох	death of atten	slan	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 4☐Pregnant at	2 Fetal c	death 3	Ectopic pre					Date of delive Month	Day Year
M	o.	the d	Physician/M	1 □ Yes 2 Ø No 9 □ Unknown	9□ Unknown	01 000	0	Outer (Spe	3011y)					
2	α.	w requires that the death cer been signed by the attendin should be detached for use		Part II. Other significant conditions	contributing to death be	ıt not result	ting in the un	iderlying ca	ause give	n in Part I.	23e. Did t	obacco use co	intribute to th	ne cause of death?
B	ecords,	requires seen sign hould be	d by								10	Yes 2 No	3 🗆 Prob	ably 4 Unknown
0	S	law rec as beer 2 shou	Completed		,						24a. Was		. Were auto	psy findings available
6 7	Re	The lar	omp				_					rmed?	prior to cor death?	mpletion of cause of
d	Vital	iing Physician: The lav n. After this certificate has funeral director, page 2	Be C	25. Was case referred to medical						26. Place of Death	(Check anly o	2 No	1 Yes	2 No
2		Physician: rthis certific ral director,	To B	examiner?	Hospital:	nt 2 🗆 E	R/Outpatient	3 □ DO:	A Othe				ther (Specifi	HOSERE
2	of	g Ph er th		27. Manny of Death	28a. Date of Injur (Month, Day	y 2	28b. Time of Injury		Bc. Injury Work		28d. Describe I			Julia
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8	ĭ Vis	r Atte	tific	3 Suicide 6 Could not to determine	28e. Place of Inju	ry - At hon	ne, farm, stre	et, factory,	, office	2	28f. Location (5 City or Tox		nber or Rura	l Route Number,
lssand		rs aft rs aft al Di	Cer		4					l li				
H		tospi t hou uner	ledical	(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of	of my know	rledge, death	occurred a	at the time	e, date and place, a	and due to the	cause(s) and a	manner as st	ated.
0		To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ht completely filled in by the funeral director, page	Medi	one)	and manner sta	ted.								
		with 70	-	29b. Signature and title of certifier	Dur. D.	11	7	29c.	License	1)/h		29d. Date sign	Month,	Day, Year)
	,	_		10/W/////	MINUL	NU		1/	110	012		10/30	1/13	7
	1	//		30. Name and address of person who	eompleted cause of de	eath (Item 2	23a) (Type,	rinu 1	111	and F	I To	34/61	MIN	21710
	9			31. Date filed (Month, Day, Year)	32. Registra	r's Signatu	////	WES	WO	100 14	Fl	410)	11/11	42/6
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		*		MILLA	LUUU ANDRE	Who do	-							

		•	For State Registrar	State of M	laryland /		rtment of Hotificate of L		d Mental Hy	/giene Reg. No.	05	35378
	Diii		1. Decedent's Name (First, Middle, La	ast)					2. Date of D Month	eath Day	Year	3. Time of Death
	Physicia /Medic		ROBERT			J	PAC		OCTOBE		2005	4:34 PM
	Examin		4a. Facility Name (If not institution, gir	ve street and number	)		4b. City, Town, or		eath	4c. Co	unty of Deeth	
L			JOHNS HOPKINS B	1 1 1 1 1 1 1 1 1	EDICAL (S	NER.	BALTIN If Under 1 Year	If Under 24	Hrs. R Date of Bi	dh	0 Righ	plece (Stete or Foreign
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Ů.			Usual Residence of Decedent						1404 .20	7 1740		
	how		10a. State 10b. County		10c. City, To							10d. Inside City Limits
	Ba-1-s	cto	MD Howard	<u>d</u>	EL	krid	9					1 ☐ Yes 2 XNo
	th with th	Funeral Director	10e. Street and Number 8031 Keeton Road	đ			10f. Zip Code	<b>21</b> 0 <b>7</b> 5		10g. Citizen	USA	ntry?
21215-0036	tiges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "naturel", or items 23s or 28s-f show or other traumatic event, the Madical Examinational tendified at	by	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 Tyes 2 2 If Yes, Give Year or Dates	? I No	1 15	Vas Decedent of His Yes, specify Cubar ☐ Yes 2X No	panic Origin , Mexican, P Specify:	? (Specify Yes or N uerto Rican, etc.)		Race - Amen Black, White, Pecify: Whi	etc.
2-0	72 ho	ted	15. Decedent's E (Specify only highest gi		168		ent's Usual Occupa kind of work done d		working	16b. Kind	of Business/Ir	ndustry
21	thin 7	Completed	Elementary/Secondary (0-12)	College (1-40)		life. [	OO NOT use retired)	3111g 11103t 01	Horking	Chal	C M	1 4
21	filed wi Hygien other th			41	5	ecur		10 Mathada	Name (First, Middle	.]		aryland
Maryland	should be fi nd Mental H marked ott umatic ever	To Be	17. Father's Name (First, Middle, Las Clarence Alto					Ruth			reider	
	and 2 sho ealth and n 27 ie ma		19a. Informant's Name/Relationship Peeggee Day - wi				-		r Rural Route Numb Elkrdige,		own, State, Zij 10 <b>7</b> 5	o Code)
Baltimore,	ages 1 a ant of Hea nt: If item y or othe	Peeggee Day - wife  8031 Keeton Road, Elkrdige, MD 2107  20a. Method of Disposition  1										own, Stete
Baltir	permit. Pages Department of I Important: If ite any injury or of		21. Signature of Funeral Service Lice		M0098	22	Name and Address	of Facility	. Lohrmani ires Drive	- PΔ		21286
	40200		23a. Pert1. Enter the disease, or con	nolications that cause							son, M	Approximate
	Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Brown Due to (or a	STEN s a consequence	of):	OMPRESS	ion				Interval Between Onset and Death
	bet sit	nlner										
,0928	cate be executed ohysician and the burial-transit	a any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										
.O. Box 6	death certifi e attending f id for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2 ☐ Fetal deat at time of death		Ectopic pregnancy Other (specify)			23d	. Date of deliv Month	ery Day Year
Ω.	se us	þ	Part II. Other significant conditions HYPERTENSI		but not resulting	in the ur	derlying cause give	n in Part I.				the cause of death?
Il Records,	The law ate has b page 2 sl	Completed							24a. Wa: auto peri 1 🗆 Yes			opsy findings available impletion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe	~	Death (Check only			
of	Phys this al din	٦.	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of In		utpatien Time of	28c. Injury	4   Nursir	ng Home 5 Res 28d. Describe			fy)
no	ding h. After fune	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, E	ay Year)	Injury	Work	es 2 □ No	204. 2630106	now injury or	ocurrou	
Division	or Attending uter death. Director: After in by the fune	Certification:	3 Suicide 6 Could not determined	be 28e. Place of I	njury - At home, tetc. (Specify)	farm, stre	eet, factory, office			(Street and N wn, State)	lumber or Rur	al Route Number,
	To the Hospital or Attant within 24 hours after death To the Funeral Director: completely filled in by the	edical Ce	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the besiminer: On the basis	of examination a	ge, death ind/or inv	occurred at the tim restigation, in my op	e, date and p	lace, and due to the	cause(s) and, date and pla	d manner as s	stated. to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner :	siateu.		29c. License	number		29d. Date si	igned (Month,	Dey, Year)
1	F3F8		) Set )	def	M.D.		RES	~000	<b>&gt;</b>	CTOB	EK 2	7 2005
1	4			completed cause of	death (Item 23a	(Type,	ST. Tou	UERII	O. BALTI	HORG	, 170 2	21287
100	Sta Registi		31. Date filed (Month, Day, Year)  NOV 0 2 200	32. Regis	trar's Signature	1000	W.					

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	_		1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>		Health and	Mental Hy	/giene Reg. <table-cell> . (</table-cell>	n en en	35379
ı	Physici		1. Decedent's Name (First, Middle, La	Louise	DONH	AM		2. Date of D Month	eath Day	Year	3. Time of Death 2.40 P M
	/Medio Examir			LICOTT CI		Eluco	or Localion of Deat	h	4c. C	ounty of Death	ny
	Funeral Director		5. Social Security Number 214–38–6463  Usual Residence of Decedent	Sex 7. Age	65 Yrs.	If Under 1 Yea Months Day			irth ay, Year) •1940		place (State or Foreign http) antown, WV
	ne Maryland Be-f ahow pilitied at	Director	10a. State 10b. County  MD Howard		10c. City, Town or Le Elkridge					1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with th		10e. Street and Number			10f. Zip Code				in of What Coul	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 Ia marked other than "natural", or Itams 23a or 28e-1 ahow any injury or other traumatic avant, the Madical Examinat must be notified at once.	by Funeral	5921 Autumn Spe11  11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent If Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:	In	U21075 Was Decedent of If Yes, specify Cu 1☐ Yes 2█ N	Hispanic Origin? (S ban, Mexican, Puen o Specify:	pecify Yes or N to Rican, etc.)	0- 14	Race - Americ Black, White, pecify: Whit	elc.
21215-0036	un 72 ho n "natur Madical	Completed by	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	(Give	denl's Usual Occ kind of work don DO NOT use retii	upation e during most of wo ed)	rking	16b. Kind	of Business/In	
d 212	filed with Hygiene ther tha		10  17. Father's Name (First, Middle, Last		Elec	ctronic .	Assembler			ctronic	cs
ylan	Mental Mental arked o	То Ве	Homer Jacob Donh				Bertha				
Maryland	alth and 2 should be stored to 127 la must be streams		19a. Informant's Name/Relationship ( Carolyn Donham /				st and Number or Ri Spell, El				(Code)
Baltimore,	Pages 1 annent of He ant: If itam		20a. Method of Disposition  1X Burial 2 Cremation 3 4 Donation 5 Other (Special		20b. Place of Dispo cemetery, cre		1	Date 8/2005		tion - City or To	
Balt	I Secretory		21. Signature of Funeral Service) Licer  23a Part 1. Enter the disease of rom shock, or hear failure List only Immediate Cause (Final	MO] plications that caused one cause on each lin	250 Wash ter the mode of dy	man Funer ington Bl ring, such as cardiad	vd., Ell or respiratory	@ Mea kridge arrest,	dowride, MD 2	æMem. Park	
8760,	/Medical Examiner bhysician and bhysician and the prizer transit the prizer transit.	Ical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a Due to (or a) Due	a consequence of):  THMA a consequence of):  Consequence of):  BETES		s cell	C AICC			
P.O. Box 68	Attanding Physician: The law requires that the death certificate be executed rideath.  r death. actor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnan Other (specify)	су		23	d. Date of delive	ory Day Year
	w requires that in the properties of the propert	by	Part II. Other significant conditions of		it not resulting in the u	nderlying cause g	iven in Part I.				ne cause of death?
I Records,	The law re ate has bee page 2 sho	Completed	HYPERLIA	DEMIA.			* 100 14 1010	24a. Was auto perf 1 Yes		prior to cor death?	psy findings available appletion of cause of 2 2 No
Vita	ysician: The is certificate hadirector, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2 ☐ ER/Outpatier	nt 3 DOA	26. Place of Deather:	th (Check only		Other (Specifi	<i>(</i> )
Division of Vital	r Attanding Physer death. ractor; After this by the funeral di	Certification; 7	27. Manner of Death  1. Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b	28a. Date of Injur (Month, Day	y 28b. Time o Year) Injury	f 28c. Ing W M 1[	ury at ork? ∐Yes 2 ☐ No	28d. Describe	how injury o	occurred	
<u>&gt;i</u> Q	in Direct		4 Homicide determined	building, etc				City or To	wn, State)		l Route Number,
	To the Hospital within 24 hours a To tha Funaral I completely filled	ledical	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	examination and/or in	vestigation, in my	opinion, death occu	rred at the time,	date and pl	ace, and due to	the cause(s)
^	To Tool	M	29b. Signature and title of certifier	PRINAR	7 CARE	Do	8 5 4 9 4		0	signed (Month,	2005
16	d		JAMES TAN	completed cause of de	eath (Item 23a) (Type,	Print)  ARA	ony pla	CE BA	LTIMO	RE MD	21201
2	Sta Registr	ar	31. Date filed (Month, Day, Year)		r's Signature	Losse	ony pla				
υH	MH 17 Rev 1/2	<i>,</i> 01		7	ORIGINA	Car					

			For		State	of Mary	/land / Dep		t of H	lealth a	and N	nental Hy	giene	Logibio.		
			1 - State Registrar	14:-1-11- 1			Ce	ertificat	e of i	Death			Reg. No.	2005	353	3.8.0
	Physicia	an	1. Decedent's Name (First,		151)							2. Date of De Month October		2005 Year	3: IMe 6	- M
	/Medic Examin		Hattie C. Em		ve street and nu	ımbər)		4b. City.	Town, or	r Location o	of Death			County of Dea		рМ
	Examili	C1	7466 Furnace Br	_		,			Elen I	Burnie				,		
	Funeral		5. Social Security Number		Sex 1 □ M 2 🕅 F	7. Age (li	n yrs. last birthda	-	1 Year Days		24 Hrs. Min.	8. Date of Bir (Month, Da 04-24-19	th ly, Year)	9. Bi	rthplace (State o	or Foreign
	Director		215-24-6975 Usual Residence of Decede		1 M 2 LOU.F		85 Yrs.			167		04-24-19	20		th Caroli	na
	land ow		10a. State 10b. Co			10	Oc. City, Town or	ocation							10d. Inside C	ity Limits
	Mary B-1 sh	tor	MD Anne	Aruno	le1		G	len Bur	nie						1 □ Yes	2 🛣 No
	or 28	by Funeral Director	10e. Street and Number					10f. Zip	Code				10g. Citi	zen of What C	ountry?	
	ath w	la l	7466 Furnace B	ranch						.060				USA		
	ler de	une	11. Marital Status 1 ☐ Never Married 2 ☐	Marriad	12. Was Dec	edent Eve orces? 2 XNo	rin U.S. 13	If Yes, spe	dent of H cify Cuba	lispanic Ori an, Mexicar	gin? (Sp n, Puerto	pecify Yes or No Rican, etc.)	-	14. Race - Am Black, Whi		
936	urs aff	by F	3 XWidowed 4 □ Divi		If Yes, G	ive		1 ☐ Yes	2 <b>™</b> No	Specify:				Specify:	Black	
2	within 72 hours after death with the Maryland ene. than "neturel", or Items 23a or 28e-1 show the Modical Examiner mart be motified at	Be Completed		edent's E	ducation ade completed	)	16a. Dec	edent's Usu	al Occup	ation	t of work	ring	16b. Ki	nd of Business		·
7	vithin De. Dan "	mple	Elementary/Secondary (0			(1-4or 5+)	life	DO NOT u	se retired	d)	. Or WOIN	9		ъ		
2	Iled w Tygier ther th	S	17. Father's Name (First, Mi		t)		1	Housew	ife	18 Mothe	ar's Nam	e (First, Middle,	Maiden	Domesti	LC	
and	d be f ental h ced of	o Be	John Brown	00/0, 240	.,					TO. INIO(TIE				Jumamey		
Maryland 21215-0036	should be filed vand Mental Hygies marked other turnatic event, III	T <sub>o</sub>	19a. Informant's Name/Rela	ationship	(Type, Print)		19b. Ma	ling Address	(Street	and Numbe		enny Euri		Town, State,	Zip Code)	
	and 2 Balth a m 27 is		Irene Jones/ Da	ughte	r		130	Sloane	Drive	e Glen	Burn	ie, MD 2	1060			
ore	of He of He fitem r oth		20a. Method of Disposition 1 XBurial 2 ☐ Crema	ition 3.	Removal from	State	20b. Place of Dis cemetery, cr	osition (Nar ematory or o	ne of other plac	се)		Date	20c. Lo	cation - City o	r Town, State	
Ĕ	Pages tment of I tant: If ite jury or or		`4 □ Donation 5 □ Oth	er (Spec	ify)	Otato	Woodlawn (				L1 <b>-</b> 03	<del>-</del> 05	Balti	more, MD		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28e-1 show eny injury or other traumatic event, It is Modical Examination that be multified at once.		21. Signature of Funeral Se	rvice Lice	mset			22. Name ar			•	N. G:1	~			
			23a. Part1. Enter the disease	se, or con	nplications that	caused the						N. Gilmor		Balto, M	D 21217 Approximat	6
	Pnysician		shock, or heart failure. Immediate Cause (Final	List only	one cause on	each line.				1.000					Interval Bet Onset and I	ween
	/Medical		disease or condition resulting in death)		a Due to	(or as a co	onsequence of):	OVILL	-	200		edder			muse	4
	Examiner		Sequentially list conditions.	- 1	b											
	sit sit	liner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Į	Due to	(or as a co	onsequence of):									
	xecuti and	Examiner	that initiated events resulting in death) Last		c. Due to	(or as a co	onsequence of):									
8760,	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	calE		Į	d.											
89	tificat ng phy as th		IE EE WA													
Box 6	th cer tendir or use	Physician/Med	IF FEMALE: 23b. Was decedent pregnal in the past 12 months?		23c. If yes, ou 1☐Live			□Ectopic p	egnancy	,			2	3d. Date of de		rear .
о П	the at	/sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		4□Preg 9□ Unkr	nant at tim	e of death 5	Other (sp	ecity)					MOUTH	Day	eai
P. 0.	ires that the death certific signed by the attending p d be detached for use as		Part II, Other significant co	nditions	contributing to	death but n	ot resulting in the	underlying c	ause give	en in Part I		23e. Did to	obacco u	se contribute t	o the cause of d	leath?
Records,	luires n sign ald be	d by	Chron	1'C	Kidn	42	disco	<				1 🗆 ነ	res 2	No 3□P	robably 4 50	Jnknown
CO	sw requires been si	Completed	Cheme	Shal	matrie	gow	Granow	diss	2021	_		24a. Was		24b. Were a	utopsy findings	available
Be	Physicien: The lav this certificate has ral director, page 2	mo				0	1					autor perfo	rmed?	death?	completion of ca s 2□ No	ause of
ita I	sien: artifica ctor, j	Be C	25. Was case referred to me examiner?	edical							of Deat	h (Check only o				
\ \ \	hysic this co	10	1 ☐ Yes 2 ☑ No			Inpatient	2 ER/Outpati		and the same of	40110	rsing Ho	ome 5 Resid			ecify)	
uc C	ding F	tlon:		ending		of Injury oth, Day Ye	ear) 28b. Time Injury	ot 2 M	8c. Injun Work	yat k? Yes 2 ⊡l	No	28d. Describe I	now injury	occurred		
Division of Vital	l or Attending after death. Director: After I in by the fune	flca	3 ☐ Suicide 6 ☐ G	ould not l	28e. Plac	e of Injury	- At home, farm, s			.00 20		28f. Location (S	Street and	d Number or A	lural Route Num	ber,
ă	el or / s after ol Dire	Certification:	4  Homicide		build	ling, etc. (3	Specify)					City or Tov	vn, State)			
	To the Hospitel or Attending I within 24 hours after death.  To the Funerel Director: After completely filled in by the funer		29a. Certifier 1 Certifier 2 Me	rtifying P	hysician: To th	e best of m	ny knowledge, dea amination and/or	th occurred	at the tin	ne, date an	d place,	and due to the	cause(s)	and manner a	s stated.	)
	the hin 24 the F	Medical	one) 29b. Signature and title of co		and mar	ner stated				e number				signed (Mon.		
	Wil To	_	A An	0	MA			290		-40	521				1, 2005	-
_	2		30. Name and address of pe	erson who	completed car	se of death	h (Item 23a) (Tyn	, Print)	275	flosz		1000		neto ?	228	
3	/ /		DROCHA					01	en 1	Bur	vic.		210	61		
	Sta		31. Date filed (Month, Day,	Year)		Registrar's	Signature	Joseffe	\$							
Г	Registr	ar	NOV	0 2	2005	A SENSO	J S5 1	1								

			For State Registrar	State of N		Depart		ealth and	Mental Hy	-	35381
	Physici /Medic		1. Decedent's Name (First, Midd RAYMON)	CLAK		= F	TRST		2. Date of Dea		3. Time of Death  10.30AM
	Examin Funeral		4a. Facility Name (If not institution BALTIMORE)  5. Social Security Number	REHABILIT	AT ION Age (In yrs. last b	EXTE	o. City, Town, or in the control of	If Under 24 Hrs	BALT/	4c. County of De	irthplace (State or Foreign
	Director		216-40-0176 Usual Residence of Decedent	1☑M 2□F		Yrs.	onths Days	Hours Min		y, Year) 10,1944 Ma	Country)
	e Maryian le-f show	ctor	10a. State 10b. County  Maryland	Baltimore	10c. City, To	wn or Locati	ion	Ro	sedale		10d. Inside City Limits 1 ☐ Yes 2 No
	th with th	al Dire	10e. Street and Number 1210 Kruger	Avenue			10f. Zip Code	21	237	10g. Citizen of What United	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If itam 27 is marked other than "netural", or Itams 23e or 28e-f show important: If itam 27 is marked other than "netural", or Itams 23e or 28e-f show pay injury or other traumatic avant. The Modical Extra cit at the Indition of an once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Mar  3 □ Widowed 45⊖Divorced	If Yas Give	s?	10	Decedent of Hises, specify Cuban Yes 212 No	spanic Origin? (9 n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ar Black, W Specify:	nerican Indian, hite, etc. White
21215-0036	within 72 hound and the within "neturing the managed to the manage	Completed	(Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed)	16	a. Decedent (Give kind life. DO	's Usual Occupated of work done do NOT use retired)	uring most of wo	orking	16b. Kind of Busines	ss/Industry
Maryland 2	should be filed with nd Mental Hygiene. marked other the imatic avant, III.	To Be Co	12 Years 17. Father's Name (First, Middle, Raymond First			Tri	ick Driv	18. Mother's Na	me (First, Middle, erine Cla	<u>U.S. Arm</u> Maiden Sumame) ark	У
e, Mary	1 and 2 sho Health and t am 27 is me ther traums		19a. Informant's Name/Relation Melissa L. Fit 20a. Method of Disposition		er)	1103 (	Glemsfor	d Road		er, City or Town, State Baltimore,  20c. Location - City	MD 21221
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If itam 27 is any injury or other tra once.		1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (3	Specify)	10	ison H		. A. Ce		,	s Mills, MD
Ba	permi Depa Impo any is		Veta Ca	an .	and the death D	Du 6	22 Wise	Funeral Ave. D	undalk,		21222
	Physician		23. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	only one cause on each	TE	MY	O EAR	Such as cardia	AL IN	FARCTI	Approximate Interval Between Onset and Death
	/Medical Examiner	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a Du	as a consequence  BETE  as a consequence	1	ME	Ujj	TUS		
3760,	ate be executed hysician and the burial-transit	cal Examiner	Cause Chief Orlowing Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or	as a consequenc	e of):					
P.O. Box 68	death certific e attending p ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal dea at time of death		opic pregnancy her (specify)			23d. Date of o	elivery Day Year
	law requires that the death as been signed by the atte 2 should be detached for	ed by Ph	Part II. Other significant conditions of the CHRDNIC	ons contributing to death	but not resulting	in the under	rlying cause giver	in Part I.			to the cause of death?  Probably 4 🛣 Unknown
al Records,	The ate ha	Completed by					DISC	EASE	24a. Was a autop perfor	an 24b. Were prior to death?	
Division of Vital	To the Hospitel or Attanding Physician: Th within 24 hours after death. To the Funaral Director: After this certificate completely filled in by the funeral director, pag	on: To Be	25. Was case referred to medical examiner?  1 Tyes 2 No  27. Manner of Death  1 Natural 5 Pendi	Hospital: 1 Inpa		. Time of Injury	Other 28c. Injury: Work?	4 Nursing I		ne) lence 6 Other (Sp low injury occurred	ecify)
Divisio	To the Hospitel or Attanding within 24 hours after death. To tha Funaral Director: After completely filled in by the fune	Certification:	2 Accident invest 3 Suicide 6 Could 4 Homicide deterr	nined 286. Place of	Injury - At home, etc. (Specify)			es 2 □No	28f. Location (S City or Tow	Street and Number or I rn, State)	Rural Route Number,
	To the Hospitel within 24 hours a To the Funeral completely filled	edical	one)	ng Physicien: To the be Examiner: On the basis and manner	i of examination a	ge, death oc and/or invest	igation, in my opi	nion, death occi	e, and due to the curred at the time, c	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
)	Mith Co Co Co Co Co Co Co Co Co Co Co Co Co	×	29b. Signature and title of certific	A Has	line	MD	0.24	648	1	29d. Date signed (Mo.	
5	>*/~		30. Name and address of person	ASHMI 1	40 3	900	LOCH	RAVI	EN BL	10 BB	7/MORE 21218
	Sta Registr		31. Date filed (Month, Day, Year	0V 0 2 2005	strar's Signature	2 5	Jane	P			

			State of Ivial	•	epartment of r Certificate of			3eg. Nø?   1   1   5	35382
		1. Decedent's Name (First, Middle, Le.	st)				2. Dete of Dee Month	oth Dey Yea	3. Time of Death
	Physician /Medical	Elizabeth Fu	lham				Novemb	-	
	Examiner	4e Fecility Name (If not institution, give	e street and number)			4b. City, Town, or I		4c. County of De	
1	Zamiret	Sacred Heart	Home			Hyattsvi	11e	Prince (	George's
7	Funeral	5. Social Security Number 6. S	ex 7. Age	(In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day	9. E	Birthplace (State or Foreign Country)
	Director	095-16-8191 Usuel Residence of Decedent	□ M 2/DXF	94 Y	Months Days	Hours Min.	May 19,		Country)  Ireland
	and and	10a. Stete 10b. County	1	10c. City, Town	or Location				10d. Inside City Limits
	ter death with the Marylan terms 23a or 28a-f show ther mast be notified at unerral Director	MD Prince G	eorge ! s	Laui	501				1 □ Yes 2∜□ No
	vith the Mar t or 28a-f sl be notfiled Director	10e. Street end Number	corge s	паці	10f. Zip Code		1	10g. Citizen of What	Country?
	3a o	9010 Briarcroft	Tano		207			US	27
	me 2	11. Marital Status	12, Was Decedent Ev	er in U,S.	13. Was Decedent of H If Yes, specify Cub		pecify Yes or No-		nerican Indian,
20		1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes ※※ No If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes 2 ☑ No		o Rican, etc.)	Black, Wi	
ဗို	ed within 72 hours a ygiene.  Ser then "netural", of it, the Wedical Exam.  Completed by	15. Decedent's Ed	lucation	16e. D	ecedent's Usual Occur	pation		16b. Kind of Busines	ss/Industry
Maryland 21215-0020	n n n n n n n n n n n n n n n n n n n	(Specify only highest gra	de completed)		Decedent's Usual Occup Give kind of work done ife. DO NOT use retire	during most of word)	king		
21	7 5 5 5	12th	College (1-4or 5+)		wner-Opera	tor		Stationa	ary Store
B	be filed that Hygie of other event, Be Cc	17. Father's Name (First, Middle, Lest)				18. Mother's Nan	ne (First, Middle,	Maiden Surname)	
<u>a</u>		Patrick O'Sull	ivan			Elizabe	eth Corbe	ett	
an	s 1 end 2 should if Health end Man Item 27 la marke other traumatic	19a. Informant's Name/Relationship (	Type, Print)	19b. I	Mailing Address (Street	and Number or Ru	ral Route Numbe	r, City or Town, State	, Zip Code)
Ž	1 end 2 Health em 27 l	Kevin G. Fulham/S	on	994	Pacific S	treet, Ba	aldwin, 1	NY 11510	)
<u>S</u>	of Head	20a. Method of Disposition		20b. Place of Cometery.	isposition (Name of crematory or other pla	ce)	Date	20c. Location - City	or Town, State
Ĕ	Pages nant of nt: If Its iry or o	14 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			of Heaven		1/4/05	Silver Spr	ing, MD
Baltimore,	permit. Pages Department of Important: If It any Injury or once.	21. Signature of Funeral Service Licen	see		22. Name and Addre				
Ö	Per la di	DWH C	Ih MC	0773	313 Talbot				
THE STATE OF	Physician /Medical Examiner	23a. Pert1. Enter the disease, or comp shock, or heart failure. List only Immediate Ceuse (Final disease or condition resulting in death)	a. Pneum						Approximate Interval Between Onset and Death
	executed to end riel-trensit		b. Sepsi						
ć	exect in end iel-tre	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events	Di	ue to (or as e co	nsequence or):				
68760,	ificate be executed g physician end es the buriel-trensit	Cause (Disease or injury that initieted events resulting in death) Last	c	e to (or as a cor	nsequence of):				
			d						
Box	at the death cert d by the attendin eteched for use Physician/M								
P.O.	the de shed shed	Pert II. Other significant conditions co	entributing to death but i	not resulting in t	ne underlying cause giv	en in Part I.	23b. Did to	bacco use contribu	te to the causa of death?
σ.		Hypertensive (	Cardiovascu	lar Dis	ease		1 □ Y	es 2.21 No 3.□	Probably 4 Unknown
Vital Records,	The law requiras that the death cer sate has been signed by the attendir page 2 should be deteched for use Completed by Physician/A						24a. Was a		Were autopsy findings available prior to completion of cause of death?
æ	The law ata has b page 2 s						1 🗆 Y	es 21 <b>3</b> 110	1 ☐ Yes 2 No
ta	entifica actor, p	25. Was case referred to medical				26. Place of Dea	th (Check only on		
>	Physician: this certific tral diractor,	examiner?	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outp	atient 3 DOA Oth		-	ence 6 ⊡Other <i>(Sp</i>	pecify)
	arthii eral	27. Manner of Death	28e. Date of Injury (Month, Day Y	28b. Tin	ne of 28c. Injur			ow injury occurred	
0	Attending or death.  Ctor: After by the fune lification	1 ← Natural 5 ☐ Pending 2 ☐ Accident investigetion		'ea <i>r)</i> Inju		Yes 2 □ No			
Ź I	tal or Attending P rs after death. al Director: After t led in by the funera Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury building, etc. (		, street, factory, office		28f. Location (St City or Town	reet and Number or in, State)	Rural Route Number,
	To the Hospital or Attending Physician: The law require within 24 hours after death.  To the Funeral Director: After this certificata has been si completely filled in by the funeral director, page 2 should Medical Certification: To Be Completed	29a. Certifier Certifying Phyone) 2 Medical Exam	velcian: To the best of n iner: On the basis of ex and manner stated	camination and/c	leath occurred at the tin or investigation, in my o	ne, date and place, pinion, death occur	and due to the cared at the time, d	ause(s) and manner ate and place, and di	as stated. ue to the cause(s)
	Within To th Comp	29b. Signature end title of certifier		_	29c. Licens	e number	2	9d. Date signed (Mo	nth, Dey, Yeer)
	10	lix	rales 1	W	D005	1122	N	lovember 1	. 2005
	1//	30. Name end address of person who	completed cause of deet	th (Item 23e) (Ty					, 2000
	H	Dr. Juanitez, $\vee$	1160 Varnu	m Stree	t, N.E. Su	ite 208,	Washingt	on, D.C.	20017
2 6	State	31. Dete filed (Month, Day, Year)	32 Registrer's		Contes				

			1 - For State Registrar	State of Man		artmen rtificat				lental Hy	/giene Reg. No. <sup>C</sup>	71105	35	383
	Physici	an	1. Decedent's Name (First, Middle, Last	•						2. Date of De	eath Day	Year	3. Time	of Death
1	/Medi				Lee Friel					Octobe	er 26	, 2005	3:27	РМ
4	Examir	ner	4a. Fecility Name (If not institution, give	street and number)			_	Location of	of Death			County of Death		
			12502 Ivory Pass  5. Social Security Number 6. Se	7 Acc //	n yrs. last birthday)		rel	If Under	24 Hrs	0 Cata at B:		rince Ge		
	Funeral Director			M 2⊠F 7. Age (7. Age		Months	Days	Hours	Min.	8. Date of Bi (Month, Di Apr 09	ay, Year)	9. Birth	place (State intry)	
			Usuel Residence of Decedent							Apr 03	, 19.	tz   Mass	sachus	etts
	filed within 72 hours after death with the Maryland Hygiene. ther then "neturel", or Items 23a or 28a-1 show int, the Mydical Examination profiled at	_	10a. State 10b. County	10	Oc. City, Town or Lo	cation							10d. Inside (	
	ith the Marylar or 28a-1 show	cto	MD Prince G	George 1	Laurel								1 🗆 Ye	s 2⊠No
	or 26	Funeral Director	10e. Street and Number			10f. Zip	Code				10g. Citiz	en of What Cou	intry?	
	ath w	ral	12502 Ivory Pass			207	80				U.S	S.A.		
	tems	nne	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Deced	lent of His	spanic Ori n, Mexican	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)	o- 1	<ol> <li>Race - Ameri Black, White</li> </ol>		
36	s afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 No		1 ☐ Yes	2 <b>∑</b> No	Specify:				Specify:		
21215-0036	hour hour	edt	15. Decedent's Edu	Year or Dates:	16a. Deced	dont's Heus	I Occupa	ntion			16h Kin	Whi		
15	in 72	Completed	(Specify only highest grad	le completed)	(Give	kind of wor DO NOT us	rk done d se retired)	uring mos	t of worki	ing	TOD. KIN	d of Business/Ir	ndustry	
212	with jiene	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Offic						Com	municat	ions	
ğ	othe othe	Be C	17. Father's Name (First, Middle, Last)				_		r's Name	(First, Middle			.10115	
<u>lar</u>	Alenta Alenta rked tic ev	To B	Clarence Bassett					ALbe	erta	Northw	ay			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. them "neturel", or Items 23a or 28a-1 show item 27 Is marked other then "neturel", or Items 23a or 28a-1 show other treumatic event, the Modical Examinational profiled at		19a. Informant's Name/Relationship (T)	ype, Print)	19b. Mailir	ng Address	(Street a	nd Numbe	or Rura	l Route Numb	er, City or	Town, State, Zij	o Code)	
	of Health of Health item 27 I		David J. Friel /	spouse	1250	2 Ivo	ry P	ass,	Laur	cel, Ma	rylan	d 20708		
ore			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🕅	Compared from State	20b. Place of Dispo cemetery, cren	sition (Nan	ne of ther place	9)		ate	20c. Loc	ation - City or T	own, State	
Ĕ	nit. Pages artment of h ortant: If its injury or of	100	'4 □Donation 5 □ Other (Specify)	taineval iloni otate	Arlington				Nov	30, 05	Arli	ngton,	Virgin	ia
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens	99/	22	. Name an	d Addres	s of Facilit	v	Iome, P				
ш_	90 E # 9		& Hulffy la		<u> 100773   3.</u>	<u>13 Ta</u>	lbot	t Ave	e. La	urel,	Maryl	and 207	07-438	89
			23a. Part1. Enter the dispase, or comp shock, or heart failure. List only o	lications that caused the ne cause on each line.	death. Do not ente	er the mode	e of dying	, such as	cardiac o	r respiratory a	rrest,		Approxima Interval Be	ate etween
	Physician		Immediate Cause (Final disease or condition	Cerebral	Thrombos	is							Onset and	Death
	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):									
	Examine	_	Sequentially list conditions,	b. Hypercoac		ate								
	led rsit	nine	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	`	7	_								
_	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Cancer of Due to (or as a co		5								
8760,	ate be executed hysician and the burial-transit													
9	ificate I g physi as the t	edicai		u.										
Вох	eath certific attending pl	M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		le .					23	3d. Date of delive	ery	
	deati e atte	icia	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown		JEctopic pre Other <i>(sp</i> e					111	Month	Day	Year
P.0	requires that the death certific een signed by the attending p nould be detached for use as	Physician/M	9 Unknown											
	res that igned b	by	Part II. Other significant conditions co	ntributing to death but n	ot resulting in the ur	nderlying ca	luse givei	n in Part I.			_	e contribute to t		
Vital Records,	w requir been si should	ompieted	Asthma							1 🗆	Yes 2∐	No 3 ☐ Prot	pably 4 🔀	Unknown
ec	8 8	npie								24a. Was autor	osy !	24b. Were auto	psy findings mpletion of a	available cause of
E		Co								1 Yes	rmed? 2X No	death? 1 ☐ Yes	2 🗆 No	
Vita	Physicien: T this certificat al director, pa	Be	25. Was case referred to medical examiner?	Hospital:						(Check only o				
ō		٠. T	1 Yes 2 XNo	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatient		A Injuny	4 Nu		ne 5 🔀 Resid		Other (Specif	y)	
Division	Attending Phr r death. ector: After thi by the funeral	ertification;	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	nar) Injury	M	Bc. Injury Work	? es 2 □ t		.ou. Describe	now injury	occurred		
/isi	r Attendi ter death. Irector: A r by the fu	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury			1 7					Number or Rura	ul Route Nun	nber,
ă	of Direction	Cert	4  Homicide determined	building, etc. (S	Specify)					City or Tov	wn, State)			
	Hos Fur Pely	edical (	29a. Certifier 1 🔀 Certifying Physical (Check only one) 2 Medical Exami	sicien: To the best of m ner: On the basis of exa and manner stated	y knowledge, death amination and/or inv	occurred a restigation,	it the time in my opi	e, date and inion, deat	d place, a	and due to the	cause(s) a date and p	nd manner as s place, and due to	tated. the cause(s	5)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c.	License	number			29d. Date	signed (Month,	Dey, Year)	
	1	2	marker U. L	Ulltzin		I	02374	13			Octo	ber 27,	2005	
16	7//		30. Name and address of person who co			,								
1 -			Martin Weltz, M.D		enway Dri	ve, (	reer	nbelt	, Ma	ryland	2077	0		
	Sta Registr	1.0	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	_								

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. Mo. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Kathleen Elizabeth Fogle October 27, 2005 11:25pmM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glade Valley Nursing Center Walkersville Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Mar 15, 9. Birthplace (State or Foreign Country) Maryland **Funeral** Days 1 □ M 2 🕅 F 219-20-4375 Vrs Director 1928 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County show 10d. Inside City Limits ral', or Itams 23a or 28e-f shov Exemities a ust be notified at 1X Yes 2 □ No Director Maryland Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 56 West Frederick Street 21793 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be tiled within 72 hours after cent of Health and Mental Hygiene.
nns til titem 27 is marked other than "netural", or Iter
nry or othar traumatic event, Iter Marical Estania.
nry or othar traumatic event, Iter Marical Estania. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 6 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Ray Welty P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William J. Fogle - Son 208 Albany Avenue W, Walkersville, MD 21793 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Glade Cemetery Oct 31, 2005 \* 4 ☐ Donation 5 ☐ Other (Specify) Walkersville, Maryland 21. Signature of Funeral Service Licensee <sup>22</sup> Name and Address of Facility Keeney & Bastord P.A. Funeral Home M00706 106 Fast Church St, Fredericl Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 106 Fast Church St, Frederick, Maryland 21701 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial Infarction 1 day /Medical Due to (or as a consequence of). Examiner Chronic Obstructive Pulmonary Disease <u>5 years</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) physician a s the burial Box 68760. Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. I ed by the a detached f Yes 21 No 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 🗌 Yes 2 X No 2 No or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: P 1 ☐ Yes 2 🔀 No Other: 4 🛛 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Medical Certification: injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gerard A. DelGrippo, M.D., 63 Thomas Johnson Drive, Frederick, Maryland 21702 31. Date filed (Month, Day, Year) 39. Registrar's Signature State NOV 0 2 2005 Registrar

ORIGINAL

				State of Maryland / De	partment of H	Health and M	•	9	
				1 - State Registrar	ertificate of	Death	Reg	No2 11 15	35306
	ı	Physici /Medic		Decedent's Name (First, Middle, Last)     HELEN ELIZABETH FAY			2. Date of Death Month	Day Year	BZS PM
	1	Examir		4a. Facility Name (If not institution, give street and number) Fran Llin Square Hospita	4b. City, Town, o	or Location of Death		4c. County of Dear Baltin	th
		Funeral Director		5. Social Security Number  6. Sex 1		Hours Min.	8. Date of Birth (Month, Day, Yo 11/19/19	ear) 9. Biri	thplace (State or Foreign ountry) RYLAND
		ט		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or	Location			72 TAP	10d. Inside City Limits
		death with the Maryland ms 23e or 28e-f show	ector	MD BALTIMORE LOCH  10e. Street and Number	RAVEN VII	LLAGE			1 ☐ Yes 2 ☐ XNo
		th with 23e or 3	Funerai Director	1866 EDGEWOOD ROAD	10f. Zip Code	1234	10g.	. Citizen of What Co USA	ountry?
	9			1 ☐ Never Married 2 ☐ Married   1 ☐ Yes 2 ☐ÑNo		Hispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
	21215-0036	filed within 72 hours atter Hygiene. ither than "naturel", or Ite ent, The Moulcal Examilies	ted by	3 XWidowed 4 □ Divorced If Yes, Give Year or Dates:  15. Decedent's Education 16a. Dec	1 ☐ Yes 2 No	pation	161	Specify: Williams. b. Kind of Business.	HITE Industry
	1215	within 7 ene. than "n	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	ve kind of work done b. DO NOT use retire OMEMAKER	during most of workir d)	ng	OWN HOME	•
1	Ind 2	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Last)	orien mater (	18. Mother's Name			
13	Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than any injury or other treumetic event, The M. QDCE.	To	JOHN PUELTZ  19a. Informant's Name/Relationship (Type, Print)  19b. Ma	illing Address (Street	ANNA To		ity or Town, State,	Zip Code)
7	e,	1 and 2 Health a em 27 la			1 WADSWORT		LTIMORE,	MD 21239 c. Location - City or	
plen	Baltimore,	Pages ment of ent: If it ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State DUCANEY	'°VACCEY°'ME DENS	FR)		OCKEYSVILI	
101	Balt	permit. Depart Import any inj	I	21. Signature of Funeral Service Licensee		ess of Facility THE H RAVEN BL			HOME, P.A. 1286
17				23a. Part1. Enter the disease, or complications that caused the death. Do not enhock, or heart failure. List only one cause on each line.	enter the mode of dyir	ng, such as cardiac or	r respiratory arrest,		Approximate Interval Between Onset and Death
		Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a.   Asplication  Due to (or as a consequence of):	Phec	monic	<u>)                                    </u>		ia hours
			Jer	Sequentially list conditions, if any, leading to immediate cause. End. Stage.  Due to (or as a sonsequence of):	Demen	itia			
		te be executed ysician and e burial-transit	Examiner	Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):					
	38760,	w - w	cai	d					
	P.O. Box 68	To the Hospitel or Attending Physicien: The law requires that the death certificate is within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b.	Physician/Med		B Ectopic pregnancy Cother (specify)	у		23d. Date of del Month	ivery Day Year
		es that the gned by be detac	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause giv	en in Part !.	23e. Did tobac	co use contribute to	the cause of death?
	cord	w requires that been signed E should be deta	Completed	Renal failure			1 Tes		obably 4 Unknown  topsy findings available
	Division of Vital Records,	: The la cate has ; page 2					autopsy performed 1 Yes 2	prior to death?	completion of cause of
	Vit	siclen certif rector	Be	25. Was case referred to medical examiner?  Hospital:	ont 30 DOA Oth	26. Place of Death			
	oţ	Phys r this ral di	1: To	1 Sinpatient 2 ER/Outpati	ent 3 DOA	4 Inursing Hom	ne 5 Residence 8d. Describe how i	e 6 Other (Specialized	cify)
	sion	tending leath. tor: Afte the fune	catior	1)⊠Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	M 1	Yes 2 □No			
	Divi	itel or At rs after c el Direc ed in by	Certification:	4 Homicide determined 286. Place of Injury - At home, tarm, so building, etc. (Specify)			City or Town, S		
		ne Hospi n 24 hou ne Funer bletely fill	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de: 2  Medical Examíner: On the basis of examination and/or and manner stated.	ath occurred at the tir investigation, in my o	me, date and place, a ppinion, death occurre	nd due to the caused at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
		withi To th	Me	29b. Signature and title of certifier	29c. Licens	se number 060576		Date signed (Month	
	1	0	0	30. Name and dress of pe son who completed cause of death (Item 23a) (Type DR Jeanette Krolikowsk, 9000 Frau	e Print)			,	
	8	Sta Registr		31. Date filed (Month, Day, Year)  NOV 0 2 2005	Joseph .	TALL TALL	QUIT (MOLL)		-(6.3

			1 - For State Registrar	State of M	Maryland		artmen rtificate			nd M	_	giene Reg. No.	C) C) pm	35387
	D.		1. Decedent's Name (First, Middle, La	st)							2. Date of De Month	ath Day	Vone	3. Time of Death
	Physici /Medi		SUSANA PHILLI	PS FENOR	F						OCTOB	$ER \frac{Day}{2}$	4, 2005	7:05 P M
	Examir		4a. Facility Name (If not institution, giv	e street and number	r)		4b. City,	Town, or	Location of	Death		4c.	County of Deal	h
	w~ V		220 31st STREET						RE CI					
h	Funeral Director		5. Social Security Number 6. S 213-48-7734	ex   7. A □M 21√2 F	lge (In yrs. la 57	ast birthday) Yrs.	If Under Months	Days	Hours	Min.	8. Date of Bir (Month, Da 08/01	iv. Year)	9. Birt	hplace (State or Foreign
2	4.		Usual Residence of Decedent	Λ							08/01	./19	48 MAR	RYLAND
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	a-f-	ctor	MD		B.	ALTIM	ORE							1 Yes 2 □ No
	or 28	Director	10e. Street and Number				10f. Zip					10g. Citi:	zen of What Co	ountry?
	ath w	rai	220 EAST 31ST					212				US		
	er de İtemi	Funerai	11. Marital Status	12. Was Deceden Armed Forces	?	3. 13.	Was Deced f Yes, spec	lent of History of Cubar	spanic Origi n, Mexican,	in? (Spec Puerto P	cify Yes or No Rican, etc.)	)-	<ol> <li>Race - Ame Black, White</li> </ol>	
36	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🕱 Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	-		1 ☐ Yes 2	2 X No	Specify:				Specify: WH	ITE
5-0036	72 hours after death with the Maryland natural', or items 23s or 28s-f show dical Exerciner must be ricitified at	ted	15. Decedent's E	ducation		16a. Dece	dent's Usua	al Occupa	ition				nd of Business/	
215	within 7 ene. than "n	pie	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or	r 5+)	(Give life.	kind of wor DO NOT us	rk done d se retired,	uring most (	of workin	g			•
2121	filed wil Hygien ther th	Completed		4YRS		UNKN	OWN					UN:	KNOWN	
nd	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Me	Be	17. Father's Name (First, Middle, Last,					İ			(First, Middle.			
<del>Z</del>	ould Men narke	70	FRANK WILLIAM		<b>)</b>	· · · · · · · · · · · · · · · · · · ·					ORIEG			
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan to Health and Mental Hygiene. If item 27 is marked other than "natural", or iteme 23s or 28s-f ehow or other traumatic event, the Madical Exercine must be retilified at		19a. Informant's Name/Relationship ( MICHELLE PHIL		ו משתי								Town, State, Z	
	1 and Health Iem 27		20a. Method of Disposition	T112/212	20b. Pla	ace of Dispo	sition (Nan	ne of			WHII		cation - City or	21161 • Town. State
ē	Pages nent of int: if it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification 5)	Removal from State	A I	metery, crer EN MO				2 Y 1 O	1/29/2		•	. CITY, MD.
Baltimore,	- 든뿐글		21. Signature of Furgeral Service Licer		71.2.	22	. Name an	d Addres	s of Facility					
ä	Depa Impo any in		Well	dest		H	ENRY 6924	W.	JENI RK RI	KINS	& SONKTON	NS (	CO. 2111	1
	W		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	ed the death.									Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ATHE	Rosci	EROTT.		C MA	010 1	Aec	INASK	015	EX VE	Onset and Death
0	/Medical Examiner		resulting in death)	Due to (or a	s a consequi	ence of):			<u> </u>	7130	NAK	71-	.0.45	
ķ.	* *	_	Sequentially list conditions,	b. Due to /or a	s a conseque	ance of):								
id	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury	Due to (or a	s a conseque	erice or).								
,	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or a	s a conseque	ence of):								
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai	(	d										
68	ng ph as th	ledi	IS ESTABLE.											
Вох	death certifica eattending pt d for use as ti	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic pre	egnancy				2	3d. Date of deli	,
O.E	at the dea by the at tached fo	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown	4☐Pregnant a 9☐ Unknown			Other (spe			_			Month	Day Year
P.0	that the		Part II. Dther significant conditions of	ontributing to death	but not recul	ting in the u	adorhina ac	NURO ONO	n in Dod I		230 Didte	phases III	no contributo to	the cause of death?
of Vital Records,	signe d be	d by		oriting to douting	Dat Hot 163ai	ang at the di	identying ca	ausa giva	maraici.					obably 4 Minknown
Š	v requii been s should	Completed												
Re	The lav	E G									24a. Was autop perfo		prior to death?	topsy findings available completion of cause of
ta		O O	25. Was case referred to medical						00 81	15		2 □ No	1 Yes	2 □ No
5	Physician: r this certific ral director,	To B	examiner?  TX Yes 2 No	Hospital:	ient 2 🗆 E	R/Outpatien	t 3 🗆 DO	Δ Dthe			(Check only o		XOther (Spec	(ity) SCENE
o	ding Phy n. After thi funeral c		27. Manner of Death	28a. Date of Inj	ury 2	28b. Time of		Bc. Injury Work			3d. Describe f			(ally) DCIERIE
jo	Mtendin death. ctor: Aft y the fun	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	1	ay (Gal)	Injury	М		r ′es 2∐No	0				
Division	f or Atten after deat Director: I in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Ir	njury - At hon		et, factory,	, office		28	Sf. Location (S City or Tox	Street and	<i>Number or R</i> u	ral Route Number,
Ω	lospitaf o hours af uneral D ily filled in													
	T 4 T 0	edicai	29a. Certifier 1 ☐ Certifying Ph (Check only 2 🖫 Medical Examone)	ysician: To the best niner: On the basis of and manner s	of examination	rledge, death on and/or inv	occurred a restigation,	at the time in my op	e, date and inion, death	place, ar occurred	nd due to the d d at the time,	cause(s) : date and	and manner as place, and due	stated. to the cause(s)
	To the Vithin 2 To the Complet	Mec	29b. Signature and title of certifier	and mainer s			29c.	License	number	-		29d. Date	signed (Month	i, Day, Year)
	- 5 - 0		· austo	,				OCME	E				OBER 25	
	17		30. Name and address of person who	completed cause of	death (Item :	23a) (Type,	Print) 11	.1 Pe	nn St	reet	Balt			1and 21201
	\		ANA RUE	10, MD									-, IMIL Y	
*	Sta Registr		31. Date filed (Month, Day, Year)		trar's Signatu	ire	elle)							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. Mo. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 14 Year 0 2005 Month Day FRANK SYLVIA 5,10AM 0 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 □ F 105-03-9381 86 Yrs NC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A BALTIMORE 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7301 PARK HEIGHTS AVENUE #104 21208 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No WHITE Specify: 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALES PERSON DEPARTMENT STORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) BENJAMIN HYMAN FRIDA HAYMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANDREA SCOTT / DAUGHTER 7301 PARK HEIGHTS AVENUE #207 - BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) PARK 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State OHEB SHALOM MEMORIAL 11/01/2005 \* 4 ☐ Donation 5 ☐ Other (Specify) REISTERSTOWN, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VIMOMARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

10a State

MD

Director

Funeral

Completed by

Be

**Funeral** 

Director

item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural, or Item any injury or other traumatic event, the Medical Examples 2008.

Baltimore, Maryland 21215-0036

the Maryland

Examine Physiclan/Medical þ Completed Be ပ Medical Certification; þ

29b. Signature and title of certifier

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jan

attending physician and for use as the burial-transit

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

within 24 hours after deal To the Funeral Director: completely State

F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ How 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 □Ectopic pregnancy		23d. Date of delivery Month Day Year
ant II. Other significant condition	ns contributing to death but not re	sulting in the underlying cause given in Part I.	0110	co use contribute to the cause of death?
		<u> </u>	24a. Was an autopsy performed	
5. Was case referred to medical examiner?		26. Place	of Death Check only one)	
1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA Other: 4 Nur	sing Home 5 Residence	6 □Other (Specify)
7. Manne Death 1 atural 5 Pending 2 Accident investige	28a. Date of Injury (Month, Day Year) ation	28b. Time of 28c. Injury at Work?  M 1 Yes 2 N	28d. Describe how in	njury occurred
3 Suicide 6 Could no 4 Homicide determin	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)

DHMH 17 Rev 1/2001

Registrar

Begistrar's Signation

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 3 per doc 2019 11-2-05 vt
State of Maryland / Department of Health and Mental Hygiene 0 0 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year steen 7:42 P M ctaber o-venna 2005 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Baltimore Tospital If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In y s. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign **Funeral** -9076 1□M 2**V**F Days Min. Hours Yrs. Director land 27,1961 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Examiner must be multimad at 1 √Yes 2 No Completed by Funeral Director 7 more Maruland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ngtiel a Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yas 2 No Specify: Blac 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) DUSC WITE C 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fil ment of Health and Mental H tant: If item 27 is marked otl Be ဥ ormi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Batte NID AIR I 000 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State pernit. Page Depurtment of Important: If any injury or once. Cemetery -2005] 4. Donation 5 ☐ Other (Specify) Irini Joseph L. Muss F 21 Signature of Funeral Service Licenses Home, P.A. Touch L. Kuss Funeral iss Balto, MD 21212 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death PIRATORY Priysician HOURS /Medical Due to (or as a consequence of): Examiner ASPIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed use as the burial-transit ROGRESSIVE signed by the attending physician and d be detached for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? TRACHEOSTOMY 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No peen : 24b. Were autopsy findings available prior to completion of cause of death? MONARY EMBOLIC 24a. Was an has autopsy neral Director: After this certificate filled in by the funeral director, pag RESPIRATORY 1 Yes 2 No 1 ☐ Yes 2 ☐ No CHRONIC To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 Yes 20 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification; To 1 Inpatient 2 KER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 63 OCTOBER 31 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNIVERSITY MD Rich MD Acim BAL

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 0

32. Registrar's Signature

		i lease	State of Maryland	/ Department of			•	
		1 - Stete	State of Maryland	Certificate o		1.7	71115	35390
		Registrar  1. Decedent's Name (First, Middle Last	)	Och inicate o		Reg. P	NO.	3. Time of Death
Physic		11110. (2)	arrett			Mgnth ) - 2	8- Q'S	4:100 M
/Medi Exami		4a. Eacility Name (If not institution, give	street and number)	4b. City, Town	, or Location of Death	, ,	4c. County of Dear	h 7
		LV9 Hall	Geriatric (	enter Bo	Himore			
Funeral		5. Social Security Number 6. Se	7. Age (In yrs. la	st birthday) If Challed Yes Months Day	rs Hours Min.	3. Date of Birth (Month, Day, Yea	9. Bird	hplace (State or Foreign
Director		Usual Residence of Decedent	83	115.		5-31-2	2. MU	ssissippi
yland Now		10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
Mar-fs-fs-filled	tor	MD	Bo	1 timore				1 Yes 2 □ No
ith the	Oire	10e. Street and Number		10f. Zip Code	•	10g. (	Citizen of What Co	untry?
72-0030 72 hours after death with the Marylar "naturel", or items 23e or 28e-f show idical Examinar i ust be molified at	Funeral Director	4809 Al thea	Allenne	212	06		XSA	
er de Item	une	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	i. 13. Was Decedent o	if Hispanic Origin? (Sp <i>ec</i> uban, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Ame Black, Whit	
urs aff	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 📉	lo Specify:		Specify: R	ack.
2 hou	ted	15. Decedent's Edu	cation	16a. Decedent's Usual Occ	cupation	16b.	Kind of Business	Industry
thin 7	Completed	(Specify only highest grad	College (1-4or 5+)	life. DO NOT use reti	ne during most of working ired)			1
be filed within 72 hours after death with the Maryland tall Hygiene. Identities then "naturel", or items 23e or 28a-f show event. The Medical Examinar must be multiped at	Sol	3 KD	!	Machin	15+	لل	Naus	strial
Lai yiaitu K.I.K. 2 should be filed withir and Mental Hygiene. Is marked other then eumatic event. Interns	Be	17. Father's Name (First, Middle, Last)	. 0		18. Mother's Name (	rirst, Middle, Maid	en Sumame)	no. 1
it yid should ad Men marke matic	2	19a, Informant's Name/Relationship (Tr	(De. Priat)	19b. Mailing Address (Stre	net and Number or Rural	Route Number City	JOJIM 2 v or Town, State, J	Zip Code)
		10 Mar Charat	+ Grandson	)4809 AI	Thea. A.	w. Bak	6 MA	11106
s 1 and if Health item 27 other tr		20a. Mathod of Disposition	20b. Pla	or of Disposition (Name of metery, crematory or other p	Da	te 20c.	Location - City or	Town, State
Pages nent of int: If it		1 Burial 2 □ Cremation 3 □ F 1 Donation 5 □ Other (Specify)	Removal from State	risanitorosti	Cometon 111	14/05/	) unast	VIII MI
permit. Page Department of Importent: If any injury or once.		21. Sand, re of Funeral Service Licens	ee	ame and Add	of Facility	tuno	ral ser	sices
Dep Dep Dep Dep Dep Dep Dep Dep Dep Dep		130 Clot	~ MUI363	49052	Poek 200	d, Bal	to MP 2	1212
		shock, or heart failure. List only o	ications that caused the death. ne cause on each line.	Do not enter the mode of	ring, such as cardiac or	respiratory arrest,	18-2-211 11	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	a. Havan	red D	ernonti	2		an Known
/Medical Examiner		rosaning in doutry	Due to (or as a conseque	ence of):				
	ig G	Sequentially list conditions, if any, leading to immediate	b Due to (or as a conseque	ence of):				
d d ansit	Examiner	Cause (Disease or injury	c.					
be executed sician and burial-transit		resulting in death) Last	Due to (or as a conseque	ance of):				
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artifica ing ph	Med	IF FEMALE:		777.70				
ath ce	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal of	death 3 ⊟Ectopic pregnar			23d. Date of del Month	ivery Day Year
he de	ysic	1 ☐ Yes 2 ⊡ No 9 ☐ Unknown	4□ Pregnant at time of dea 9□ Unknown	ath 5 ☐ Other (specify)				
w requires that the death certificate to ensigned by the attending physishould be detached for use as the	by Physician/Med	Part II. Other significant conditions co	ntributing to death but not resul	ting in the underlying cause	given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
quires t		Type II D	abetes,	CHF.		1 🗆 Yes	2 No 3 Pr	obably 4 Donknown
w req	Completed					24a. Was an	24b. Were at	topsy findings available
The la	Eo					autopsy performed	death?	completion of cause of
lan: T	Be C	25. Was case referred to medical			26. Place of Death		10 1 13	22.10
Physic this ce	70 6	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 3 DOA	Other: 4 Nursing Home	e 5 Residence	6 □Other (Spe	cify)
ing PI		27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. In Injury W		ld. Describe how in	jury occurred	
tandi death. tor: A	cat	2 Accident investigation 3 Suicide 6 Could not be	20 81 41		☐Yes 2☐No	of Landian (Carana	and Mumber of D	and Dougla Marahas
or Al after of Direction by	ertification:	4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, street, factory, offic	e 28	If. Location (Street City or Town, Sta		rai Houte Number,
spital ours ours illed	O	29a. Certifier 1 Certifying Phy	sician: To the best of my know	ledge, death occurred at the	time, date and place, an	d due to the cause	(s) and manner as	stated.
To the Hospital or Attanding Physician: The law requires that the death certifica within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as it	edicai	(Check only 2 Medical Exemi	ner: On the basis of examination	on and/or investigation, in my	y opinion, death occurred	at the time, date a	and place, and due	to the cause(s)
To th within To th comp	Me	29b. Signature and title of certifier	•	29c. Lice	nse number	29d. [	Date signed (Mont	h, Day, Year)
	-	Me M.	ρ .		-38754 TERN BL	1 10	7-151-	2005
5		30. Name and address of person who ca	ompleted cause of death (Item :	23a) (Type, Print)	TRAN RI	ND	110-	11221

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

			For State Registrar	State of Ma	ryland / Depa Cei	artment of H rtificate of I		/lental Hy	giene Reg. Wo. 0	5 35391
	Physici /Medic		Decedent's Name (First, Middle, La.	Ulyss	es Gambl	e		2. Date of De Month	Day 7	Year G: 15 A M
^	Examin		4a. Facility Name (If not institution, give Union Memorial			4b. City, Town, or Balto	Location of Death		4c. County o	
	Funeral Director		231 33 3170	ex 7. Age ✓ M 2 F	(In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Date of Bir	rth ay, Year) 4-1936	9. Birthplace (State or Foreign Country) S.C.
	and **		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Maryl f sho	ō	Md Harfor	<b>1</b>	Belcamp					1 □ Yes 2 No
	r 288	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Country?
	h with	a D	4243 Goodson Ct			21	017		USA	
21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Exerciser must be notified at	d by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Wildowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba		pecify Yes or No Rican, etc.)		- American Indian, k, White, etc. Black
5-(	72 h "natu	etec	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Deced	dent's Usual Occupa kind of work done of DO NOT use retired	ation Juring most of work	ung	16b. Kind of Bus	siness/Industry
121	within iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	DO NOT use retired Laborer	)		Constr	uction
d 2	filed with Hygiene. other ther		3rd grade  17. Father's Name (First, Middle, Last)		N/A		18. Mother's Nam	e (First, Middle	, Maiden Sumame	a)
<u>a</u>	ld be tental rked c	To Be	B. F. Gamble				Sylveste:	r Hallu	ms	
Maryland	2 should be fi and Mental h is marked ot aumatic ever		19a. Informant's Name/Relationship (	Type, Print)	19b. Mailir	ng Address (Street a				State, Zip Code)
	of Health of Health item 27 i		Kareema Dent - N	iece		3 Goodson		-	d 21017	
Baltimore,	2 = 5		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	20b. Place of Dispo cemetery, cren King Mem	sition (Name of natory or other place orial Psr	l l	Date -2005		City or Town, State
Balti	permit. Pag Department Importent: I any injury o		21. 3grature of Funeral S. rvine Licen	Sep		. Name and Addres		March F		
	131		23a. Part1. Enter the disease or comshock, or heart failure. List only	plications that caused	tre death. Do not ent					Approximate Interval Between
ı	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Pulm	where e	mbole	35			Onset and Death
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	and transit	kamin	if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. Dua to /or as a	consequence of):					
68760,	ficate be executed physician and is the burial-transit	edical Examin		d	consequence or).					
O. Box	The law requires that the death certificate has been signed by the attending prage 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	Petal death 3	Ectopic pregnancy Other (specify)			23d. Date Mont	o of delivery th Day Year
Δ.	w requires that been signed b should be deta	þ	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the ur	ndertying cause give	n in Part I.			bute to the cause of death? 3 ☐ Probably 4 ☐ hknown
of Vital Records,		Completed	2010						ormed? pr	fere autopsy findings available not to completion of cause of path?  Yes 2 100
Vita	Physician: this certificant	Be	25. Was case referred to medical examiner?	Hospital:		104	26. Place of Deat	h Check only o	one	
o	Phys r this ral din	- T	1 Yes 2 No	28a. Date of Injury			4 LI Nursing Ho		dence 6 Other	
ou	ding th. After funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	28c. Injury Work	? 'es 2 \ No	Zod. Describe i	now injury occurre	u.
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	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stat	6u.	29c. License				(Month, Day, Year)
) _	- s - ö		As A	10		ATZ4	38 94 6	•	OCT	24,2005
3	N		30. Name and address of person who	-RAJA	MD		M MEM	URIAL	HOSPIT	X,MA
	Sta Registr		31. Date filed (Month, Day, Year)  NOV 0 2 2	32. Pegistral	r's Signature	este				

			For State Registrar	State of	Maryland / D		nent of H		nd Menta			e to garvee	^~~~
	Physici		Decedent's Name (First, Middle, La		ora E. Gra			Douin	Me	ite of Dea	Day	2005	3. Time of Death
5	/Medic Examir		4a. Facility Name (If not institution, give				City, Town, or	Location of		0	1	ty of Death	10:35 PM
1	2.741111		GOOD SAMARI	TAN H	OSPITAL	1	BALTI	MORE				N//	A
	Funeral Director		5. Social Security Number 6. S 238-32-1766	ex 7. □M 2√2 F	Age (In yrs. last birt	hday) If Mo	Inder 1 Year nths Days	If Under 24	Min. (M	te of Birth onth, Day	, Year) 3, 1923		ace (State or Foreign ry) Carolina
	and W		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town	or Locatio	n			1404 23	), 1923		
	Maryla	tor		√A	, , , , , , , , , , , , , , , , , , , ,	, or Localio	_	altimore					od. Inside City Limits 1 X Yes 2 □ No
	or 288	Director	10e. Street and Number		·	10	of. Zip Code			1	10g. Citizen of	f What Count	ry?
	ath w	ra	501 East Preston Stree					21202				U.S.A	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic avant, if a Medical Examiter must be resilied at ance.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Force 1  Yes 2 If Yes, Give	. Was Decedent Ever in U.S. Armed Forces? 13. Was Deceden If Yes, specify If Yes, Give 1 □ Yes 2 □			ispanic Origir in, Mexican, I Specity:	n? (Specify Yo Puerto Rican,	es or No- etc.)	Cif-		
9	72 hour		15. Decedent's Ed		16a.	Decedent's	Usual Occupa	ation			16b. Kind of I		lack ustry
21215-0036	within 7 ene. than "n	Completed	(Specify only highest gra	de completed) College (1-4		(Give kind life. DO N	of work done o	)				Begal Lau	
92	e filed within al Hygiene. I other than vant, Ire Ma	e Co	17. Father's Name (First, Middle, Last)				Laund	Iry Worke		Middle, i	Maiden Suma		
Maryland	2 should be and Mental is markad o raumatic ave	To B	James	Ratley						Je	wel Ratte	у	
Man	12 shoul h and Me 7 is mark raumati		19a. Informant's Name/Relationship (	Гурө, Print)	19b.						r, City or Town	n, State, Zip (	Code)
	Health tam 27 other tr		Sheila Cox Daughter  20a. Method of Disposition		20b. Place of cemetery		Silverbell (Name of		numore, N		d 21206 20c. Location	- City or Toy	vn. State
m 0	Pages nent of int: If i		1 XBurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		ate cemeter)		y or other plac rn Cemete	1	10/3			Baltimore,	
Baltimore,	permit. Pages 'Department of H Important: If its any injury or ot		21. Signatur of Funeral Service Licer	900 //	OKOPOR		ne and Addres	s of Facility	uneral Se e Baltimo	ervice, I			
			23a. Part1. Enter the disease, or compshock, or learn failure. List only	olications that cau	sed the death. Do no	ot enter the	1300 Et mode of dyin	<b>Itaw Plac</b> g, such as ca	e Baltimo Irdiac or respi	re, Md ratory arr	<b>21217</b> est,	14.	Approximate Interval Between
	Pnysician	8	Immediate Cause (Final disease or condition	LACT	88	SIS							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequence o	of):							
		Jer	Sequentially list conditions, if any leading to immediate	b. SEP	as a consequence	DUK							
	scuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death)	· PANC	REATITIS								
8760,	cate be executed physician and s the burial-transit	al Ex	resulting in death) Last	Due to (or	as a consequence o	1):							
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Records, P.	es De		Part II. Other significant conditions of	ontributing to deat			ing causa give	en in Part I.	23	le. Did tob			cause of death?
900	e law requir has been si je 2 should	Completed							24	a. Was ai	n 24b.	Were autops	sy findings available
<u> </u>		Com							1	perforn	ned?	death?	pletion of cause of  No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			7 DOA Othe		Death (Chec				
of	문 등 등	n: To	27. Manner of Death	28a. Date of I	njury 28b. Ti	me of	28c. Injury	at Nursi			nce 6 Oth		
sion	anding I sath. or: After he funer	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		<i>Day Year)</i> Inj	jury M	Work 1 □ Y	r? ∕es 2 □ No					
Division	al or Att after de Direct d in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Place of	Injury - At home, farr etc. <i>(Specify)</i>	m, street, fa	ctory, office		28f. Loc City	cation (Sti y or Town	reet and Numi , State)	ber or Rural I	Route Number,
	To the Hospital or Attanding within 24 hours after death. To tha Funaral Director: After completely filled in by the fune	edical C	29a. Certifier 1 Certifying Ph. (Check only one)	ysician: To the be iner: On the basis and manner	est of my knowledge, s of examination and stated.	death occu /or investig	irred at the tim ation, in my op	e, date and p inion, death (	place, and due occurred at th	to the ca	use(s) and mate and place,	anner as stat and due to t	ed. he cause(s)
	To th within To th	Ne Ne	29b. Signature and title of certifier				29c. License	number		29	9d. Date signe	ed (Month, Da	ay, Year)
)	1		Dikanne				RES	000	)		10/26	105	
1	5 1		30. Name and address of person who				_			0	,	t .	a
	Sta	te	TZUKANJI SIKAZ 31. Date filed (Month, Day, Year)		O( LOCH strap's Signature	RAU	EN R	.UU , Y	BALTIM	ORE	MD	, 2123	99
	Registr		NOVO	2 2005	Blance	M. A.	Cords						

			For State Registrar	State of Maryland		artment d			nd Mental H	2	000	35393
		)gr	Decedent's Name (First, Middle, Last)			imeate	01 0	Calli	2. Date of			3. Time of Death
	Physici /Medic		LILLIAN	L.		GERSTE	IN		Month	HT 2	y Year 8 2005	1230 M
	Examir	er	4a. Facility Name (If not institution, give st Sinai Hospital	1111		4b. City, Tov			Death	40	County of Death	
	Funeral	7 2	5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Y	ear	Te If Under 24	Hrs. 8. Date of	Birth	9. Birthi	N/A  place (State or Foreign
	Director		213-34-1995	<sup>M 2</sup> X <sup>F</sup> 95	Yrs.	Months D	ays	Hours	DEC.	25, 190	)9 Cou	MD
	land w		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation						I Od. Inside City Limits
	Mary -1 ehe	tor	MD N/A		BALT	IMORE						1 ∑ Yes 2 □ No
	or 28¢	Funeral Director	10e. Street and Number	,		10f. Zip Co	de			10g. Cit	izen of What Cour	ntry?
	s 23e	rail	2500 W. BELVEDERI					21215				USA
-	fter de	Fune	11. Marital Status 1:  1 □ Never Married 2 □ Married	2. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No	13.	Was Decedent If Yes, specify	of Hisp Cuban,	anic Origin Mexican, F	n? (Specify Yes or Puerto Rican, etc.)	No-	<ol> <li>Race - Americ Black, White,</li> </ol>	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. After then "natural", or items 23a or 28e-f show int, the Medical Examiner much be multiped at	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 💢	No	Specify:			Specify:	WHITE
5	"natu	Completed	15. Decedent's Educi (Specify only highest grade		16a. Deced (Give	dent's Usual Or kind of work di DO NOT use re	ccupati one dui	on ring most or	f working	16b. K	ind of Business/In	dustry
7	within ene. then	duc	Elementary/Secondary (0-12)	College (1-4or 5+)	SALE		etired)			12	MON HARR	215
	Hygid other	Be Co	17. Father's Name (First, Middle, Last)		JALL	.5	1	8. Mother's	Name (First, Mid	_		.13
ylar	Menta be Menta be Menta arked arked	To B	JACOB	F0	RMINS	KY		JENN]	ΙE			HARRIS
Maryland	12 shound and and and and and and and and and a		19a. Informant's Name/Relationship (Type								r Town, State, Zip	
	1 and Health		CAROLE GOODMAN /	20h Plac	e of Disno	sition (Name o	*	1	Data		, MD 211	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then "natural", or items 23a or 28e-1 ehow any injury or other traumatic event, the Medical Examiner must be notified at ones.		1 🛱 Burial 2 □ Cremation 3 □ Re 4 □ Donatiog 5 □ Other (Specify)	moval from State cem	etery, cren	natory or other	place	,	) 0/31/2005		IALETHORP	
≡ ≡	permit. F Departm Importer any injur		21. Signature of Funeral Service Licenter	ANSII		. Name and A		,				
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Ŧ	· · · · · · · · · · · · · · · · · · ·		23a. Part1. Enter the disease, or comolo shock, or heart failure. List only she	nions that caused the death. cause on each line.	Do not ente	er the mode of	dying,	such as car	rdiac or respirator	arrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Sepsis								Onset and Death
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	acuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.									
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58760		dicai	d.									
Вох	teath certifi attending I for use as	N/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnancy	, _						23d. Date of delive	rv.
	The law requires that the death certifule has been signed by the attending rage 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal de 4 Pregnant at time of death 9 Unknown		Ectopic pregna Other (s <i>pecif</i> y						Day Year
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of Vital Records,	signed to	ρ	Part II. Other significant conditions control	10 11			given	n Part I.		d tobacco u ∃Yes 2 {	se contribute to th	e cause of death? ably 4 Unknown
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<b>£</b>	The tay cate has page 2:	omp							pe	topsy rformed?	prior to con death?	osy findings available inpletion of cause of
<u>a</u>		BeC	25. Was case referred to medical				2	6. Place of	1 ☐ Yes Death Check on!	2.☑No	1 🗆 Yes	2000
<u> </u>	hysic this ce al dire	၉	1 1 1 1 1 2 2 1 1 1 1 1 1		/Outpatient	3LI DON	Other:	4 🗌 Nursır		-	S □Other (Specify	')
ב	ding P	ion	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	b. Time of Injury		njury at Work?		28d. Describ	e how injury	occurred /	
DIVISION	Attender deatler of the	fical	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home	, farm, stre			2 🗆 No	28f. Location	(Street and	d Number or Rural	Route Number
S	s after	Certification:	4  Homicide determined	building, etc. (Specify)		,,			City or 1	own, State)	)	modie (valinger,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	edical (	29a. Certifier 1 ☐ Certifying Physic (Check only 2 ☐ Medical Examine	r: On the basis of examination	dge, death	occurred at the	e time,	date and pi	ace, and due to the	e cause(s)	and manner as sta	ated.
	thin 2 the p	Med	one)  29b. Signature and title of certifier //	and manner stated.		29c Lie	oneo n	umbor		e, date and	place, and due to	the cause(s)
	E M E S		Nikhil A	garval MI	) .	250. 6	RE	5-00	26	Zad. Date	e signed (Month, L	2005
7	N	-	30. Name and address of person who corn	pleted cause of death (Item 23	a) (Type, F	Print)				1	cioves	2005
2			Nikhil Ag	aswal M	<b>D</b> .	Sino	ri	Ho.	spital	1 0	altino	ve.
	Stat Registra		31. Date filed (Month, Day, Year) NNV 0 2 20	32. Redistrar's Signature	1. Ju	park			oc spital	0		

			For State	State of Maryland		nt of Health te of Deat			ene 0 0 5	35394			
	Physicia	an	1. Decedent's Name (First, Middle, Last	)			2.	Date of Death Month	Day Y	3. Time of Death			
	/Medic Examin	al	Henry Moly 4a. Fecility Name (If not institution, give University of Mo	street and number) Lryland Medica		Baltin	on of Death	oct.	27 20 4c. County of N / /-	Death			
2004	Funeral Director	2	5. Social Security Number 6. Se			er 1 Year   If Und	der 24 Hrs. 8. rs Min.	Date of Birth (Month, Day, 11/9/19	Year) 9	Birthplace (State or Foreign Country) Masonville, MD			
	yland		Usuel Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location					10d. Inside City Limits			
	the Mar 28a-f a	Director	MD Anne Arun  10e. Street and Number	del Pa	sadena 10f. z	ip Code		10	g. Citizen of Wh	1 ☐ Yes 2 ☐ No at Country?			
	th with	al Di	8490 Byrd Road			21122			ISA				
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel; or Items 23e or 28e-f show aumatic event, the Medical East: in a final to notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates:	If Yes, sp	edent of Hispanic ecify Cuban, Mex 2 XNo Spec	ican, Puerto Ric	y Yes or No- an, etc.)		American Indian, White, etc. White			
Maryland 21215-0036	vithin 72 horne ne. han "netur	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)		vork doné during r use retired)		1	011 CO				
7 0	Hygie Hygie ther I		17. Father's Name (First, Middle, Last)		Amoco Oil			irst, Middle, M	Maiden Surname)	пратту			
ylan	should be and Mental a marked c umatic eve	To Be	Joseph Holy Jr.	Quint	19b. Mailing Addre		rances [			ata Zin Cada)			
Mar	ges 1 and 2 should to f Health and Mer If item 27 is marke or other traumatic	H	19a. Informant's Name/Relationship (T) Joan R. Holy	ype, Print)	8490 Byr					ate, Zip Code)			
	Heall Heall tem 2 other		20a. Method of Disposition	20b. Pla	ice of Disposition (N	ame of	Date	-	20c. Location - Ci	ty or Town, State			
altimore,	Pages nent of l int: If it		1 ☐ Burial 2 ☐XCremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specific	demoval from State 1	ro Cremato		10/29/	/05	Baltimor	re, MD			
Balti	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is eny injury or other trai once.		21. Signature of Funeral Service Licens	SS A	Pa	and Address of Fa	MD 21122	2		Home,P.A.			
z.	5,00 23		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lication the search the death.	Do not enter the me	ode of dying, such	n as cardiac or re	espiratory arre	est,	Approximate Interval Between Onset and Death			
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	_/Medical Examiner		resulting in dealin)	Due to (or as a conseque		70 %							
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9	tificate ng phy as the	Medic	15.55.11.5										
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rds, P.	w requires that to be the signed by should be detailed	ed by Ph	Part II. Other significant conditions co	ontributing to death but not result	ting in the underlying	g cause given in P	art I.			ute to the cause of death?			
Division of Vital Records, P.	The law re ete has bee page 2 sho	Completed						24a. Was ar autops perform 12 Yes 2	y prid ned? dea	ore autopsy findings available of to completion of cause of ath?  Yes 200 No			
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on of	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificete ha completely filled in by the funeral director, page	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	280	lome 5 Residence 6 Other (Specify)  28d. Describe how injury occurred					
Divisi	al or Attending satter death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or within 24 hours after To the Funerel Dir completely filled in	edical C	(Check only one)	viction. To the best of my know iner: On the basis of examination and manner stated.	rladge, dauth occum on and/or investigati	ed at the time, dat on, in my opinion,	e and place, and death occurred	dua to the ca at the time, da	ate and place, an	nar 35 stoled d due to the cause(s)			
	To the within To the	Me	29b. Signature and title of certifier		2	29c. License numl				Month, Day, Year)			
)	1 1		1 Htt	MD		19795	2		Oct. 2	7, 2005			
(	145		30. Name and address of person who	completed cause of death (Item:		22 Cmili	o Cours -	Ch Dal	ti marca	MD 21220			
	Sta	ate	PENALI NOTICEUJA 31. Date filed (Month, Day, Year)	32. Redistrar's Signatu	ure		1 Ovecine	ot, bal	TITTOTT	MD 21230			
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			1 - For State Registrar	State of M	aryland		artment of rtificate of			ental Hy	2	005	353	05
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3	/Medic Examir		4a. Facility Name (If not institution	HYNSON  n. give street and number)		•	4b. City, Town,	or Location	of Death	10	0 8	O3 County of Death	7:48	A
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	Funeral		5. Social Security Number		e (In yrs. las					8 Date of Bir	rth.	O Riet	place (State or	Cornign
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	rylan how		10a. State 10b. County		10c. City, 7	Town or Lo	ocation						10d. Inside City	y Limits
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	th the	Directo	10e. Street and Number				10f. Zip Code					en of What Cou	intry?	
	72 hours after death with the Maryland natural; or Items 23a or 28e-f show dical Examinatives to motified at	alD	8394 Maryland 1	Road			21122				U.S	S.A.		
	dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Decedent of If Yes, specify Cul	Hispanic Ori	igin? (Spe	cify Yes or No	)· 1·	4. Race - Amer		
9	or It		1 Never Married 2 ☐ Marr	ried 1 Tes 2 H			1 Tes, specify Cui			rican, etc.)		Black, White		
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ınd	be fi	Be	17. Father's Name (First, Middle,	•	**		0			(First, Middle,				
<u>Y</u>	ould Men Warke	2	Howard	L.		son,		Ther			١.		grove	
Maryland 21215-0036	2 sh and is m		19a. Informant's Name/Relations		+	19b. Mailir	ng Address <i>(Stree</i> 4 Marylai	t and Numbe	or Rural	Route Number	er, City or	Town, State, Zi	p Code) 1 2 2	
	l and fealth im 27 her t	1	Theresa A. Hyn	son (Mother)	001 51									
O	Pages in nent of Hant. If ite		20a. Method of Disposition 1 ☑ Surial 2 ☐ Cremation	3 □Removal from State	cem	e of Dispo letery, crer	sition (Name of matory or other pla	ice)		ate		ation - City or T		
Ë	Pa tmen tent: jury		' 4 □ Donation 5 □ Other (S	pecify)	Ceda		ll Cemete	-	1/2/0			clyn Ma:	-	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23a or 28e-1 show any injury or other treumatic event, it e Medical Examinational be notified at once.		21. Signature of Funeral Service	Licensee		MC <sup>22</sup>	Cully-Po Cully-Po O4 Mount	ess of Facility	k Fun	eral H	ome.	P.A.		
_	σΩ = <b>α</b> α		John 7	Allin		32	04 Mount	ain Ro	oad P	asaden	a, Ma	ryland	21122	
	Physician -		23a. Part. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on each in	ne.	DO NOT BITE	er the mode of dy	ng, such as	Cardiac or	respiratory at	rrest,	A. S.	Approximate Interval Between	
	/Medical Examiner	_	resulting in death)  Sequentially list conditions,	Due to (or as	a consequen	L Initial Init	John a		reish	sje .	AL EXAM	Count	Onset and De	
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 0749 AM OCTOBER Barbara C. Hill /Medical 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death Examiner SINAI HOSPITAL BALTIMORE BALTIMORE OF N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 M & F Hours Director 215-56-8204 Sep 3, 1951 Maryland Usual Residence of Decedent the Maryland 10a State 10h Counts 10c. City, Town or Location 10d, Inside City Limits or 28a-f show item 27 is marked other than "naturat", or items 23a or 28a-f shov other traumatic event, the Madical Examinar must be notified at Director Md Baltimore Randallstown 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 10303 Marriottsville Road 21133 U.S.A. death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours atter to Department of Health and Mental Hygiene. Important: If item 27 ta marked other than "natural", or item any injury or other traumatic event, II'm Madical Examiner. Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Northrop Grumman Contract Manager 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert E. Curry Marion Curry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter Hill Husband 10303 Marriottsville Road Randallstown, Maryland 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Pikesville, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 10/29/05 Druid Ridge Cemetery 21. Signature of Funeral Service Licenseq 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death! Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner FAILURE da Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit METASTATIC BREAST CANCED Due to (or as a consequence of): attending physician Box 68760 The law requires that the death certificate be cal as the Physician/Medi IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 🗀 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☑ No 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: Atter this certifice 25. Was case referred to medical examiner? 26. Place of Death Check only one) 1 ☐ Yes 2 ☑ No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Man of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3-000 0470BER 25 2005 Name and address of person who completed cause of death (Item 23a) (Type, Print) MD SiNAT 1000 Chiwi 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Ma		epartmen Certificat			nd Men	tal Hygie	2110	5	35:	397
	Physics	í	1. Decedent's Name (First, Middle, Last	")						ate of Death	Day	· · · · ·		of Death
	Physic /Medi			Joseph Em	ory Kit}	KO O						Year 05	3:27	7 A M
	Exami		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of			4c. County o		J. J. E.	<u> </u>
			Stella Maris Hos	pice Ctr.			Tov	vson			Balt	imor	ce Co.	
	Funeral		5. Social Security Number 6. Se 216-01-8003	x 7. Age ☑M 2□F	(In yrs. last birth	Months		If Under 24 Hours		ate of Birth Month, Day, Ye			place (State	or Foreign
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	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location						,	10d. Inside	City Limits
	Maryl 1 sho	0	Bali	timore					Ec	lgemere				s 2 No
	the 28a	rec	Maryland  10e. Street and Number			10f. Zip	Code				Citizen of W	hat Cou		
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	within 72 hours after death with the Maryland ene. than "naturat", or items 23a or 28a-f show the Medical Examiner much be notified at	by Funeral Director	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was Deced	dent of Hi				Jnited		can Indian.	
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	1 and 2 Health tem 27		Mrs. Catherine Szi 20a. Method of Disposition	.Manski	230 20b. Place of D	3 Lodge		est Di		-				219
Baltimore,			20a. Method of Disposition  2 □ Cremation 3 □ F	Removal from State	cemetery,	crematory or o	ne or ther place	9)	Date	20c.	Location - C	ity or To	wn, State	
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Bal	permit. Pages 1 are Department of Heal Important; if item any Injury or othe Once.		21. Signature of Funeral Service Licens	5	_		uck	Funera		e of Du lk, Mar			.c. 222	
-9	Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, If any leading to transcribe cause. Enter Underlying Cause (Disease or injury)	D	ER'S DIS	:							Onset and	J Death
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	는 무대 사람이 아이들이 아이들이 되었다.	Medical	29a. Certifier (Check only one)  1 Certifying Physical Exemination (Check only one)	sician: To the best of ner: On the basis of eand manner state	xamination and/o	leath occurred a or investigation,	at the time in my opi	, date and p nion, death o	place, and du occurred at t	e to the cause he time, date a	s) and mann nd place, and	er as st	ated. the cause(	s)
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	5		/				1)4	372	(		10/0	28/1	25	
1	1		30. Name and address of person who co	mpleted cause of dea	th (Item 23a) (Ty	pe, Print)	`		-3		10/2	1	_	
1	) ( .		DR. TARIQ MAHMO	OD 2300 D	ULANEY	VALLEY	RD.	TIMON	NIUM, 1	MD 2109	3			
	Sta Registr	150	31. Date filed (Month, Day, Year) NOV 0 2 20	32. Registrar's	s Signature	Joseph .			***************************************					

3:27 a.m.

OCTOBER 28, 2005

JOSEPH KITKO

			1 - State Registrar	State of Maryla		rtment of Health		al Hygien Reg. N	000	0 = 0 0 0
	Physici /Medi		Denald  Denald  Indicate the second of	J Kuthi	- 50		2. Da	te of Death	<sup>a</sup> Y 2005	3: Time of beath
	Examir		4a. Facility Name (If not institution, give BALTIMORE WASHINGT) 5. Social Security Number 6, Se	ON MEDICAL	ENETER	4b. City, Town, or Location BURN	n of Death	4	c. County of Death	RUNDEL
300	Funeral Director		219-32-8605 Usual Residence of Decedent	2M 2□F 69	s. last birthday) Yrs.	Months Days Hours	er 24 Hrs. 8. Da (Mc	be of Birth onth, Day, Year b. 2,19		lace (State or Foreign htty) yland
Page with the Mackage Deligious Mackage Deligious Deligi	or 28a-f ehow	Director	10a. State 10b. County  Maryland Anne A  10e. Street and Number		city, Town or Loc asadena	ation 10f. Zip Code		10- 0	itizen of What Coun	0d. Inside City Limits  1  Yes 2  No
		Funeral Di	1213 Holmewood Dri  11. Marital Status  1 □ Never Married 2 Married	VC  12. Was Decedent Ever in Armed Forces?  1 Pres 2 No	U.S. 13. W	21122 /as Decedent of Hispanic C Yes, specify Cuban, Mexica	Origin? (Specify Yean, Puerto Rican,		U.S.A.  14. Race - America Black, White, 6	an Indian,
NALD 1215-0036	'naturel', or dical Exam	þ	3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grade)	If Yes, Give Year or Dates:	16a. Decede	Yes 2 No Specify	,	16b. F	Specify: Whi	
O 0 E	Hygint, in	Be Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	life. D	O NOT use retired) it importer &			W.I. Airp	ort
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JHL more, A	ant of Health		Catherine E. Kuhl  20a. Method of Disposition  1 Surial 2 Cremation 3 CR  4 Donation 5 Other (Specify)	20b.	Place of Disposi cemetery, crema	atory or other place)	Date	20c. L	ocation - City or Tox	wn, State
Baltin			21. Signature of Fun I Service License	Linz.	22. Mc	1 Cemetery Name and Address of Facil Cully-Polynia O4 Mountain	11/02/0 ak Funera Road Pass	al Home	oklyn Mar , P.A.	yland 21122
	nysician Medical		23a. Park. Enter the disease, or complished, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Perito	nth. Do not enter	the mode of dying, such as	s cardiac or respir	atory arrest,		Approximate Interval Between Onset and Death
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[	e Fune letely fi	Medical	29a. Certifier 1 Certifying Phys. (Check only one) 2 Medical Examin	ician: To the best of my known:  On the basis of examination and manner stated.	owledge, death o ation and/or inve	ccurred at the time, date an stigation, in my opinion, dea	nd place, and due alh occurred at the	to the cause(s) time, date and	and manner as stat place, and due to the	ted. he cause(s)
الم الم	To the comp	M	29b. Signature and title of certifier	Q MD.		29c. License number	744	Och	te signed (Month, Da	ay, Year)
64	1//		30. Name and address of person who cor	The River	m 23a) (Type, Pri	21061 HA	triA GA	VIRIA	Mn	
	Stat Registra		31. Date filed (Month, Day, Year) NOV 0 2 2	32. Registrar's Signa	ature:	arte	, it will	()	1.5	

VICTOR KYLIAVAS 05-07298 RJ

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	F Cara		Registrar  1. Decedent's Name (First, Middle, Last)		Cei	incate o	Death	2. Date of De			3. Time of Death
	Physici /Medic		Viktoras Kyli	avas				Octobe	er 29, 2	2005	12:35 p. <sup>™</sup>
~:	Examin		4a. Facility Name (If not institution, give str 778 Pintail Point,		, #314	4b. City, Town Ocean	or Location of De	eath		ty of Death Cester	County
98.	Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs.	. last birthday) Yrs.	If Under 1 Year Months Day		8. Date of Bi (Month, Di 10-5-1	ay, Year)	9. Birthp Cour Germ	
	and		Usual Residence of Decedent  10a. State 10b. County		ity, Town or Lo	cation				1	Od. Inside City Limits
	Maryi a-f sho	tor	Maryland Worcester	00	cean Ci	.ty					1 XYes 2 □ No
	with the a or 28	Director	10e. Street and Number 778 Pintail Point,	94th St. #3	14	10f. Zip Code 2184			10g. Citizen of United		
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, its Medical Examinar must be notified at 2008.	Funeral		. Was Decedent Ever in U Armed Forces? 1 ☑ Yes 2 ☐ No	J.S. 13.	Was Decedent of f Yes, specify C	of Hispanic Origin? uban, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	0- 14. Ra	ace - Americ ack, White,	can Indian,
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Baltimore, Maryland 2	ild be filed lental Hyg ked other ic event,	To Be C	17. Father's Name (First, Middle, Last) Emilius Kyliavas		•		18. Mother's F Elza S	Name (First, Middle akys	e, Maiden Suma	ame)	
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<u>o</u> E	Pages nent of snt: if i		1 ☑ Burial 2 □ Cremation 3 □ Rei 4 □ Donation 5 □ Other (Specify)	moval from State MD		natory or other p ins Ceme	1	-7-2005	Crownsv	ille,	Maryland
Balt	permit. Depertr Imports Any inju		21. Signature of Furleral Service Licensee	Vayne Osterl	ing Mc	Name and Ad Cully-P 7 E. Pa	dress of Facility Olyniak tapsco A	Funeral H	Home, P. More, M	A. Jaryla	nd 21225
lis.	Physician /Medical Examiner	Examiner	23 Part. Enter the disease, or complication of the disease, or condition is as a condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):			asula		× 22.00	Approximate Interval Between Onset and Death
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S,	w requires that the been signed by the should be detache	þ	Part II. Other significant conditions control	ributing to death but not re	sulting in the u	nderlying cause	given in Part I.		tobacco use co	ntribute to t	he cause of death?
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X	To fi To the	N	b. Signature and title of certifier	mi Polo	lu .		ense number CME		29d. Date signed (Month, Day, Year) October 30, 2005		
	12		30 Name and address of person who con	npleted cause of death (Ite	am 23a) (Type,	Print) 111	Penn Str	eet Balt	imore,	Mary1	and 21201
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	Conti					

			1 - For Amend Item 23a p	State of Maryland / De	epartmer Dertificat	nt of H te of L	ealth and Death	Mental H	ygien Reg. N	e 2005	351.00
			1. Decedent's Name (First, Middle, Last					2. Date of D		8000	3. Time of Death
	Physici		Grace			VI	inger	Month	De	1	0625AM
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)	4h City		Location of De			County of Death	0000
	LAGITIII	161	Johns Hopkins Bay			time					
	Funeral		5. Social Security Number 6.3e			r 1 Year	If Under 24 Hi		irth	N/A	place (State or Foreign
	Director		10	M 2X)F 81 Yr	Months	Days	Hours Mi	n. (Month, E	lay, Year	) Coui	ntry)
	25		Usuel Residence of Decedent	01				March	8, 1	924 Penn	<u>sylvania</u>
	ylan		10a. State 10b. County	10c. City, Town o	r Location					1	0d. Inside City Limits
	Mar	ģ	Maryland Baltimo	re Dunda	l Ъ						1 ☐ Yes 2√☐ No
	128g	Director	10e. Street and Number	Le j Dunda.	10f. Zip	Code			10g. Ci	itizen of What Cour	ntry?
	72 hours after death with the Maryland natural', or Itame 23a or 28a-f show disal Examinative Inditied at		041 Oploled at the Board	D3		1000					•
	death	Funeral	941 Oakleigh Beach 11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Dece	1222 dent of Hi	spanic Origin?	Specify Yes or N	Un	ited Sta 14 Race - Americ	
က	of Ita	교	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No	tf Yes, spe	cify Cubai	n, Mexican, Pue	irto Rican, etc.)		Black, White,	
8	urs a	β	3 ₩idowed 4 Divorced	If Yes, Give Year or Dates:	1 🗆 Yes	No.	Specify:			Specify: Wh	ite
21215-0036	2 ho	ted	15. Decedent's Edu		ecedent's Usua	al Occupa	tion		16b. F	(ind of Business/In-	dustry
2	n n	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed) (C	ive kind of wo fe. DO NOT u	rk done d	uring most of w	orking			
2	the start	E	6 years	College (1-4or 5+)	mamalra	10				TIOM O	
ō	othe ent.	a)	17. Father's Name (First, Middle, Last)		omemake		18. Mother's Na	ame (First, Middle		Wn Home	
an	ld be enta ked ic ev	To B	Roy Klinger				Della	A. Ulsh			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examplest right ba notified at ORCe.	-	19a. Informant's Name/Relationship (Ty	pe, Print) 19b. M	ailing Address	(Street a			her City	or Town, State, Zip	Codel
Ž	od 2 lith al 27 is trau		Dorothy Hoffman (D.								ŕ
ģ	1 ar Hea em	133	20a. Method of Disposition	20b. Place of Di	sposition (Name	ne of	seach R	Date Dun		Marylar	
Baltimore,	ages or of		1 D Burial 2 ☐ Cremation 3 ☐ P	lemoval from State cemetery,	crematory or o	ther place	1		200. L	ocation - City of To	wn, State
뜵	t. Parturent	100	*4 ☐ Donation 5 ☐ Other (Specify)	Bel Air			THE THE PARTY OF THE PARTY.	8/2005	Bel	Air, Max	ryland
쪮	permi Depar Impo any ir		21. Signatur of uneral Service License	0 ()	22. Name an	d Address	of Facility	Home of	Dun	dalk, Ind	7
_	705 9 Q		Carridorn (	1.1cen	7922 W	ise i	Avenue	Dundalk	Ma	ryland 2	1222
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the deeth. Do not ne cause on each line.	enter the mod	e of dying	, such as cardia	ac or respiratory	arrest,	2	Approximate Interval Between
	Physician		Immediate Cause (Finat disease or condition	- Read Cailyes	Sep	gis					Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of):							
	Examiner		Conventinity list and divisor								
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):							
	cuted	Examiner	Cause (Disease or injury that initiated events								
o,	exe an ar rial-ti	EX	resulting in death) Last	Due to (or as a consequence of):							
8760,	rcate be executed physician and s the burial-transit	dical									
9	<b>*</b> 73. 2	E23									
Вох	death certific e attending p id for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy						23d. Date of delive	D/
m	atte i for	cia	in the past 12 months?		3 ☐ Ectopic pre 5 ☐ Other (spe				ĺ		Day Year
o.	by the detached	ıys	9 Unknown	9□ Unknown		00.177					
م َ	The law requires that the tte has been signed by the sage 2 should be detache	4	Part II. Other significant conditions con	tributing to death but not resulting in the	e underlying ca	ause diver	in Part I	23a. Did	lobacco i	use contribute to th	e cause of death?
Records,	sign d be	d by				<b>y</b>					ably 4 Dunknown
Ö	w require been si	Completed							103 2	<b>1</b> 21140 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	LONG TOTAL CONT.
ec	e law has t	ď						24a. Was auto	DSV	24b. Were autop	esy findings available appletion of cause of
		Ö						perfo	rmed? 2 ☑ No	death?	
=======================================	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?				26. Place of De	ath (Check only	one)	1	
_	ysic I dire	2	1 ☐ Yes 2 ☑ No	ospital: 1 ☑Inpatient 2 ☐ ER/Outpai	tient 3 DO	A Other	4 🗍 Nursing I	Home 5 ☐ Resi	dence	6 □Other (Specify	)
0	ter ti		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury 28b. Time (Month, Day Year) Injur		8c. Injury a	at	28d. Describe			
፩	ath. ath. rr: Af	atic	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(manufacty vol.)	M		s 2 No				
Division of Vital	Atte	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm,	street, factory.	. office		28f. Location (	Street an	d Number or Rural	Route Number,
5	s after	E	T Wortholds	building, etc. (Specify)				City or To	wn, State	)	
	ospit hour inere y fille		29a. Certifier 1 Certifying Phys	ician: To the best of my knowledge, de	eath occurred a	at the time	, date and place	e, and due to the	cause(s)	and manner as sta	ated.
	To the Hospital or Attending Physician: To the Fours after death To the Funeral Director: After this certified completely filled in by the funeral director.	Medical	(Check only 2 Medical Examination)	er: On the basis of examination and/or and manner stated.	investigation,	in my opi	nion, death occ	urred at the time.	date and	place, and due to	the cause(s)
	To the To the Company of the Company	ž	29b. Signature and title of certifier		29c.	License	number		29d. Dat	e signed (Month, E	Day, Year)
			During		D	-	The Second				
(			30. Name and address person who co	moleted cause of doorb (harmone)		69-	000		UCT	ober 26	7, 2005
1	10					4.4.5	0.00				
	Stat		31. Date filed (Month, Day, Year)	Registrar's Signature	LIIMIONE	INCD	2122	†			
	Registra		NOV 0 2 2005	Alexander March	aste 1						

DHMH 16 Rev 6/95

Registrar

NOV 0 2 2000

DHMH 17 Rev 1/2001

CATIOAM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2005 **Physician** 1,20 John S. Lawless November /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 30, 11 Anne Baltimore uxoning to Medical Centers. Social Security Number 6. Sex 7. Age (In yrs. last birthday ARUNAC 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F 577-38-9453 92 Yrs. Director Mass. Usual Residence of Decedent should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "natural", or itams 23a or 28a-f show 10b. County 10c. City. Town or Location 10a, State 10d. Inside City Limits ms 23a or 28a-f show 1 ☐ Yes 2 No Director Maryland Anne Arundel Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1932 Hilltop Road 20794 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WW 17 ? is marked other than "natural", or itams traumatic event, the Medical Examiner my 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specity: White ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Property Manager Federal Government 12th Grade permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is marked othe any injury or other traumatic event, ODGS. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Lawless Margaret Morah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1932 Hilltop Road, Jessup, MD Mr. Timothy Lawless (son) 20794 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) St. Joseph Ch. Cem. 11/4/2005 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ordnary **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the attending physician and hed for use as the burial-transIt Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \text{Yes} \) 2 \( \text{No} \) No 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 2 ER/Outpatient hours after death. Ineral Director: After this y filled in by the funeral di 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours a
To the Funeral I
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D4 1365 2005

State Registrar

DHMH 17 Rev 1/2001

awlers, John

32. Regisar's Signature 31. Date filed (Month, Day, Year) NOV 0 2 2005

George E

30. Name and address of person who completed cause of death (Illem 23a) (Type, Print)

HOSpital

Drive, Glen Burnie, MD

State of Maryland / Department of Health and Mental Hygiene 0 05 35404 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 30, 2005 insemme 3:20pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 304 Wellham Court Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 3-11-1929 **Funeral**  Birthplace (State or Foreign Country) 12 M 2 F Months Days Hours 2/6-20-1432 76 Director Maryland Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location r than "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 304 Wellham Court 21061 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No. If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. orces: 2 No Korea 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "ne any injury or other traumatic event, the Wides. Elementary/Secondary (0-12) College (1-4or 5+) Car Inspector 12 years B&O Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Leo Linsenmeyer, Sr. Kathleen May Kenny 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucille D. Linsenmeyer (wife) 304 Wellham Ct. Glen Burnie, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem.11-4-2005 | Crownsville, Maryland 21. Sign va e of Fune a Lervice Licensee McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave. Baltimore, Maryland 21225 J. Wayne Osterling 23a Part Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** heimer disease or condition resulting in death) one vear /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit requires that the death certificate be exec Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? hrombophle bit 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown this certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 0 1 ☐ Yes 2 ☐ No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attanding F within 24 hours after death.
To the Funeral Diractor: After 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number Coluin C. Carter, wid. eled cause of death (It an 23a) (Type, Print) 16/eu Burnie 1JISh Was 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 2 2005 NOV 0 Registrar

			For State Registrar	State of	Maryland		artment			and M		gien Reg. No	2005	351.05
39	44	/\$1,	1. Decedent's Name (First, Middle,	Last)							2. Date of De.	ath		3. Time of Death
	Physic /Medi		JACOB LINI	EN							Month	Da 3	(), 2005	11:12 AM
1	Exami		4a. Fecility Name (If not institution,	give street and numb	ber)		4b. City,	Town, or	Location of	of Death		-	County of Deal	
	*		UNION MEMORIAL	HOSPITAL			BAL	TIMO	RE				N/A	
	Funeral			6. Sex 7. 1 XIM 2 □ F	Age (In yrs. las		If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birt (Month, Da	y, Year,	)   Co	hplace (State or Foreign
	Director	0)	250-38-3535 Usual Residence of Decedent		78	Yrs.					JULY 3	0 1	927 SOUI	'H CAROLINA
	laryland •how		10a. State 10b. County		10c. City, T	Town or Lo	cation							10d. Inside City Limits
	Man,	to	MARYLAND N/A		В	ALTIM	ORE							1X Yes 2 ☐ No
	r 28e	Director	10e. Street and Number				10f. Zip	Code				10g. Ci	tizen of What Co	untry?
	th wit	a D	2327 N CHARLES	STREET				212	218			Ţ	J.S.A.	
	72 hours after death with the Maryland Insturet, or items 23s or 28e-f ehow iteal Examiner invest be ruffiled at	Funeral	11. Marital Status	12. Was Deced	lent Ever in U.S.	13.	Was Deced	ent of His	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	.	14. Race - Ame	
98	or it	Fu	1 ☐ Never Married 2 Marrie		. X No	1	1 ☐ Yes 2		Specify:	i, Fuento	nican, etc.)		Black, White	
00	urai',	d by	3 Widowed 4 Divorced	Year or Date	es:								Specify: BLA	CK
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12	within lene. then	l mc	Elementary/Secondary (0-12)	College (1-4	for 5+)								37.700.00	
	Hygid Hygid Sther		unknown 17. Father's Name (First, Middle, La	ast)		CUS	TODIA		18. Mothe	r's Name	(First, Middle,		GLASS CC	· .
Maryland	Mental Mental arked o	To Be	MATTHEW LINEN								HUGGINS			
ary	2 should and Men is marke aumatic	-	19a. Informant's Name/Relationship	p (Type, Print)		19b. Mailir	ng Address	(Street a				r, City	or Town, State, 2	Tip Code)
			Joyce Linen-Bro	own/Sister	:	601 N	. Car	roll	ton i	Ave.	Balti	more	e, Maryl	and 21217
ore	00		20a. Method of Disposition			e of Dispo	sition (Nam	e of her place	)	D	ate	20c. L	ocation - City or	Town, State
Ē	Pages ment of i ant: if its ury or o		1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  WOODLAWN CEMETERY  1.321 Streaming at 5 □ Other (Specify)								1-05	BAI	LTIMORE,	MARYLAND
Baltimore,	permit. Pag Department Important: f eny injury o		21. Signature of Facility of Section 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY 1206 W NORTH AVENUE										ERAL HOM	E P.A.
- 15			23a. Part1. Enter the disease, or co	omplications that cau	used the death. [							rest,		Approximate
	Physician		Immediate Cause (Final	T =	an line.									Interval Between Onset and Death
Parks.	/Medical		disease or condition resulting in death)	Due to (or	as a consequen		litis							1 Dows
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687	physics the t	dicai		d									_	
Вох	eath certific attending p	/We	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco									23d. Date of deli	
ğ	death death	Cla	in the past 12 months?	4□ Pregnan	h 2 Fetal de nt at time of death		Ectopic pre Other (spe						Month Month	Day Year
0	t the by the	Physician/Me	9 Unknown	9□ Unknow	m									
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ord	w require been si should b	ted									1 □ Y	es 2	□No 3□Pro	bably 4 Unknown
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		Con									perfor	med? 2 No	death?	ompletion of cause of
/ita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?						26. Place	of Death	Check only or	-	·	
o o	Physicia this cert	은	1 ☐ Yes 2 No	Hospital: 1 Inp		Outpatien			4 LI Nur	sing Hom	e 5 🗆 Reside	ence	6 □Other (Spec	ify)
	After fune	io	27. Manner of Death 1 X Natural 5 ☐ Pending		Day Year)	b. Time of Injury		work?			8d. Describe h	ow injur	y occurred	
Division	l or Attending after death. Director: After in by the fune	icat	2 Accident investigat 3 Suicide 6 Could not	t be 200 Place of	Injuny - At homo	torm other	M		es 2 N		04 1 (C		-(1)	10
	F 8 2 2 2	ertification:	4 ☐ Homicide determine		Injury - At home , etc. (Specify)	, idiin, sire	et, ractory,	опісе		4	City or Town	n, State	d Number or Hu	al Route Number,
	To the Hospitel of within 24 hours af To the Funerel D completely filled in	edicai C	(Clieck Only 2   Medical Ex	Physicien: To the best	is of examination	dge, death and/or inv	occurred a	t the time	e, date and	I place, a	nd due to the c	ause(s)	and manner as	stated.
	o the inthin i o the omple	Med	one) 29b. Signature and title of certifier	and manner	r stated.			License					te signed (Month	
	⊢s⊢ó		Xatrina	C Lamo	m, M.I	)				90				
			30. Name and address of person wh			a) (Type I	Print)	1 2	-T)	0 1	TW	٥٢٦١	DELIC J	0,200
1			Latina C. L		1.0.	Unic	n Me	mari	al 1	tuspi	tal (	301	timerco	0,2005 MD
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	Registr	ar	APUV U A	2003	was St.	6	sul.							

			1 - State Amend Item Registrar	6 per fi	f Marylar G830	12-21 <u>-</u> 6	artment of Las tificate o	f Health a of Death	and Menta		ene 0 0 5	35406		
	Physici /Medi		1. Decedent's Name (First, Middle, Carmello G.	,					Mo	ite of Death onth	Day Yea	101- 201 AM		
1	Examir	ner	4a. Fecility Name (If not institution, 420 Overbrook	-	nber)			n, or Location o onsvill			4c. County of De Balt	imore		
	Funeral Director		5. Social Security Number 219-32-9954  Usual Residence of Decedent	S. Sex 1□ M ZBF	7. Age ( <i>In yr</i> s. 91	last birthday) Yrs.	If Under 1 Ye Months Day		Min. 8. Da Min. Jar	te of Birth onth, Day, Y n 30,1	9. 8 914 Ma	Birthplace (State or Foreign Country) ryland		
	death with the Maryland ms 23a or 28a-f ahow	Director	10a. State 10b. County  Maryland Balti  10e. Street and Number			atonsv		9		10g	, Citizen of What (	10d. Inside City Limits 1 ☐ Yes 2 No Country?		
_	be filed within 72 hours after death with the Marylan tal Hygiene. tal Hygiene. do other than "natural", or items 23a or 28a-f ahow event, the Madical Examinar must be notified at	by Funerai	420 Overbrook  11. Marital Status  1 □ Never Married 2 □ Married 3 ত Widowed 4 □ Divorced	12. Was Dece	23 No e		Vas Decedent of Yes, specify C		in? (Specify Ye, Puerto Rican,	es or No- etc.)	Black, Wh	nerican Indian, nite, etc. White		
-61212	filed within 72 ho Hygiene. other than "natur ent, the Madical I	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 5	grade completed) College (1	-4or 5+)	(Give	ent's Usual Occ kind of work do OO NOT use ret Employe	ne during most ired)	of working	16	b. Kind of Busines			
/ <u>la</u> n		To Be	17. Father's Name (First, Middle, La Salvatore Liber	to				Mari	's Name <i>(First,</i> nina Di	Vencer	nco			
e, Mar	s 1 and 2 should f Health and Mer itam 27 is marke other traumatic		Jo Ann Young  20a. Method of Disposition	( <i>Type</i> , <i>Print</i> ) (Daughter	-	3 Bit	ternut	Court	Catons	ute Number, City or Town, State, Zip Code) asville, Maryland 21228 20c. Location - City or Town, State				
_	thentoriant:		1 ⊠ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	city)	riale	odlawn	sition (Name of patory or other p Cemeter	y 1:	Date 1-3-200	5 Wc	odlawn,	Maryland		
g	Deperiment of the series of th		21. Signature of Funeral Service Lie	and	A	W 1	Name and Add Ltzke Fu 30 Edmo	iners of Facility ineral ondson	Home of Ave Cat	Cator onsvi	nsville, lle, MD 2			
E	hysician burian-transit and buri	dicai Examiner	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ACU Due to (c	or as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of a consequ	uence of):	C DYS	RHYTE AL IN	FARC	TION		Approximate Interval Between Onset and Death  IMMEDIATE  AND  AND  VERRS		
The law consider the the death continued to	been signed by the ettending Eshault	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 Fetal int at time of de	death 3 🗌	Ectopic pregnar Other (specify)	псу			23d. Date of de Month	alivery Day Year		
Course that	peen signed b	by	Part II. Other significant conditions	s contributing to dea	ath but not resu	ulting in the un	derlying cause o	given in Part I,	23	e. Did tobaco		to the cause of death?		
ital hec	certificate has birector, pege 2 s	e Completed	25. Was case referred to medical		7.891			26 Plane	1	a. Was an autopsy performed Yes 2	prior to death?	utopsy findings available completion of cause of s		
To the Hospital or Attending Physician	fter this	Certification; To B	examiner?  1  Yes 2 No  27. Manner of Death 1  Natural 5 Pending 2  Accident investigat 3  Suicide 6 Could not	ack only one)  5 PAsidence 6 Other (Specify)  Describe how injury occurred										
VIO selicated	within 24 hours efter death.  To the Funeral Director:  completely filled in by the fu		4 Homicide determine  29a. Certifier 1 Certifying I (Check only 2 Medical Ex	Physician: To the baminer: On the base	g, etc. (Specify	vledge death	occurred at the	time, date and	City	or Town, St	tate)	dural Route Number, s stated.		
Tothe	within 2 To the T	Medical	29b. Signature and title of certifier  January  30. Name and address of person wh	eRgal	Dazs	27,M	29c. Licer	nse number	.6	29d.	Date signed (Mon	th, Day, Year)		
	Stat Registra			Choice.			Barr	0 /1	hd w	1998				

			For State Registrar	State of I	Marylan		rtment of F	lealth and N <i>Death</i>	dental Hy	giene Reg. No		35407
	F	*	Decedent's Name (First, Middle, I	.ast)					2. Date of De		/ Year	3. Time of Death
	Physici /Medio		Frances Ann Mi	ller					Octob	er 29	2005	4:00pm M
	Examir		4a. Facility Name (If not institution, g	ive street and numb	er)		4b. City, Town, o	r Location of Death			County of Dea	
			Greater Baltimo				Towson				Baltimo	
	Funeral Director		217-78-7063	Sex 7. 1 □ M 2 🛱 F	Age (In yrs. )	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D. 11-29-	1958	9. Bir Mar	thplace (State or Foreign burley) y land
	pug *		Usual Residence of Decedent  10a, State 10b, County		10c. Cit	y, Town or Loc	ation					10d. Inside City Limits
	Aaryli sho	ō	Maryland n/a		Ва	ltimore	2					1 X Yes 2 □ No
	the t	Director	10e. Street and Number				10f. Zip Code			10g. Cit	izen of What Co	ountry?
	death with the Maryland me 23a or 28a-f show rmust be notified at		1513 Hazel Stre	et			21226			Un	ited St	ates
	death me 2	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.	S. 13. W	/as Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or N	0-	14. Race - Ami Black, Whi	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deprmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deprument of Health and Mental Hygiene. In criteria: If item 27 is marked other than "naturel; or items 23a or 28a-f show en injury or other traumatic event, the Madical Examinar must be notified at one.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced		<b>X</b> №		☐ Yes 2 XNo	Specify:	, , , , , , , , , , , , , , , , , , , ,		Specify: Wh	
fr Francis	72 hour	ted t	15. Decedent's (Specify only highest	Education		16a. Deced	ent's Usual Occup	pation during most of work d)	(ina	16b. K	ind of Business	
3	within ne. han "	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)		onoruse retire ance Unde			In	surance	
2	filed v Hygie ther t		12 years 17. Father's Name (First, Middle, La	st)		Indire		18. Mother's Nam		e, Maiden	Sumame)	
ء سلسا	ld be lental ked o	To Be	Raymond F. Car	son, Sr.				Joan S	tubbs			
Jan Vie	2 shou and N is mai		19a. Informant's Name/Relationship			19b. Mailin	Address (Street	and Number or Rui	ral Route Numi	ber, City o	or Town, State,	Zip Code) 1226
	1 and 1 and		David Miller (h	usband)	20b. P	lace of Dispos	ition (Name of		Date .		ocation - City or	
Millimore	ages ont of the		1 ☐ Burial 2 M Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐Removal from St	ate c	emetery, crem	atory or other pla rematory		-2005			Maryland
	ortme ortme		21. Signature of Funer Chervice Lie	-	Day			ess of Facility Olyniak F				
ď	89 = 8		1 1	J. Wayne		1ng 1	30 E. Fo	rt Ave. B	altimor	e, M	aryland	21230
			23a. Part1. Friter the disease, or co shoot or hear failure. Est or	omplications that cause on each	used the deat th line.	h. Do not ente	r the mode of dyi	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ Bro	ren	m	eta	stars	n/>			
	Examiner			Due to (or	as a conseq	uence of):	$\Omega$	$\sqrt{}$				10 months
		Jer	Sequentially list conditions, I say leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a conteq	uence of):	J / C					
	ocuted nd transli	Examiner	that initiated events	с.								
8760	cate be executed physician and the burial-transit	a Ex	resulting in death) Last	Due to (or	r as a conseq	uence of):						
687	icate physi s the t	edicai		d								
BOX	attendin for use	by Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No	4□Pregnar	th 2□Feta nt at time of d	Ideath 3□	Ectopic pregnanc Other (specify) _	у			23d. Date of de Month	olivery Day Year
٥	that the de ed by the detached	hys	9 🗆 Unknown	9□ Unknow								
200	quires than signed uid be de		Part II. Other significant condition	s contributing to dea	th but not res	ulting in the ur	derlying cause gr	ven in Part I.			use contribute t	o the cause of death? robably 4 🖭 Inknown
of Vital Becords	The law requirate has been spage 2 should	Completed							24a. Wa auto per 1 Yes	opsy formed?	death?	utopsy findings available completion of cause of
÷	ician; certifica	Bec	25. Was case referred to medical examiner?					26. Place of Dea	th (Check only	one)		
>	hysic this ce at dire	2	1 ☐ Yes 2 D No			ER/Outpatien	3 DOA				6 □Other (Spe	ecify)
٤	ding Ph h. After thi funeral	on:	27. Manner of Death 1 ☑ Naturat 5 ☐ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	28c. Inju Wo	nyat onk? ]Yes 2 □ No	28d. Describe	now inju	ry occurred	
Division	death ctor: y the	ficat	2 Accident investigation of Could no determine		of Injury - At h	ome, farm, str	eet, factory, office		28f. Location	(Street ar	nd Number or F	Rural Route Number,
2	al or safter safter of in bid in b	Certification:	4 Homicide determin	building	g, etc. (Specil	(y)			City or To	оwп, State	9)	
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	edical (		Physicien: To the baseminer: On the base and manner	is of examina							
	To th within To th comp	Me	29b. Signature and title of certifier	· Clau	all	y MI	29c. Licen	se number )414-01	6	0		3042005
	120		30. Name and address of person w	ho completed cause	of death (Iter	656°C	BAU	ARLES	STRE	SET 21	204	√ SUITE 20S
	St Regist	ate trar	31. Date filed (Month, Day, Year)		gistfar's Signa		Janes					

			State of Mary	land / Depa	artment of F	lealth and N		iene 05	35408
			Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
м	Physici		Keith M. I	McGraw			Oct	31 2005 Year	5:02p <sup>M</sup>
	/Medio Examin	100	4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death		4c. County of De	
н	LAGIIII	Ŭ.	302 Holly Drive		MIddl	e River		Baltin	nore
	Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth	Year) 9. B	irthplace (State or Foreign Country)
	Director	}	219-94-9496 ** M 2   F	38 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Feb. 8,	1967 Ma	aryland
	P.		Usual Residence of Decedent	6: T					104 1-14-05-11-3-
	show	_		c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	Ba-1 s	cto	MD Baltimore	Mid	dle Riv	er			
	है <b>or</b> 2	Dire	10e. Street and Number		10f. Zip Code	0.0		og, Citizen of What (	Country?
	filed within 72 hours after death with the Maryland Hygione. the then "naturelt, or items 23a or 28a-f show ant, the Markel Examble must be notified at	Funeral Director	302 Holly Drive		212			USA	and an indian
	er de	nue	11. Marital Status  12. Was Decedent Ever Armed Forces?	in U.S. 13. \	Was Decedent of H If Yes, specify Cubi	lispanic Origin? (Sr an, Mexican, Puerto	Pican, etc.)	Black, Wh	nerican Indian, nite, etc.
ဗ္ဗ	s aft	Ϋ́F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		1□Yes 2□No	Specify:		Specify: V	Mhite
3	hour furel	be t	15. Decedent's Education	16a Dece	dent's Usual Occup	pation		16b. Kind of Busines	s/Industry
က်	n 72	iet	(Specify only highest grade completed)	(Give	kind of work done DO NOT use retired	during most of world)	king		.ccu Tech
7	with ene. ther	Completed by	Elementary/Secondary (0-12) College (1-4or 5+)	Main	tance Me	echanic	1	Neshell A	ccu recn
2	Hyg Hyg other		17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, N	Maiden Sumame)	
an	ld be ental ked o	To Be	William Somerville			Mar	y Reed		
<u> </u>	should be and Mental I s marked o	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street			City or Town, State	, Zip Code)
Ξ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygione. Importent: If item 27 is marked other than "naturely, or items 23a or 28a-1 show any injury or other traumatic event, if a Marylan Examined in ust be notified at any injury or other traumatic event, if a Marylan Examined in ust be notified at an angles.		Mary Wasilewski/mot	112	20 Bird	RiverGr	oveRoad	WhiteMA	Arsh MD
Baltimore, Maryland 21215-0036	s 1 a f Hea item othe		20a. Method of Disposition	Ob. Place of Dispo	osition (Name of matory or other plan		Date 2	20c. Location - City	or Town, State
ê	Pages nent of I ent: If its ury or o		1 ☑ Surial 2 ☐ Cremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify)	BelAir	Memoria	al  11/3	3/05	Belair N	MD
≣	artm orter injur		21. Signature of Fungral Service Licensee	1 22	2. Name and Addre	ess of Facility CO	nnollyF	unoralHe	omeofEssex
ñ	permi Depa Impo any is		K Tessal Congrel	111	300 Mac		_	re MD 2	
			23a. Part1. Enter the disease, or omplications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ent	ter the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final	etastati.	· blad	der Ca	incer.		Onset and Death
	/Medical		disease or condition resulting in death)  a. Due to (or as a co				- / /		one your
	Examiner			,					are gear
H.		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	nsequence of):		-			V
	te be executed ysician and ie buriat-transit	Examiner	Cause (Disease or injury that initiated events c.						
o,	an ar	EX	resulting in death) Last Due to (or as a co	nsequence of):					
760,		cai	d						
9	ires that the death certifica signed by the attending ph d be detached for use as th	Jed	IF FEMALE.						1
.O. Box	th cer endir r use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □		☐Ectopic pregnanc	v		23d. Date of o	•
<u>.</u>	dear death	sicia	in the past 12 months?  1 Yes 2 No 9 Unknown		Other (specify)	,		Month	Day Year
<u>Ч</u>	at the by th	hy	9 Unknown			-1.			
	gned be de	by	Part II. Other significant conditions contributing to death but no	t resulting in the u	inderlying cause giv	ven in Part I.			to the cause of death?
ord	w requir been si should	ted					18016	es 2 No 3	Probably 4 Unknown
ဝင	lawr as be 2 sh	ple					24a. Was ar autops	y prior t	autopsy findings available o completion of cause of
œ _	The ate h	Completed					perform 1 ☐ Yes 2	ned? death'	
ita	Physicien: The law requires that the death certifica this certificate has been signed by the attending phrail director, page 2 should be detached for use as It.	Be (	25. Was case referred to medical examiner?				th (Check only on	e)	
<u>_</u>	hysic lidire	To	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient	2 ER/Outpatier	III 3LI DOA	ner: 4 ☐ Nursing H	<del></del>	nce 6 □Other (Sp	pecify)
0	ng Pl fter t	iuo	27. Manner of Death  1. Natural 5 Pending  28a. Date of Injury (Month, Day Ye	28b. Time o lnjury	Wo		28d. Describe ho	w injury occurred	
Division of Vital Records,	Attending r death. sctor: After by the fune	Certification:	2 Accident investigation			]Yes 2□No			
Ë	br Att	H.	4 Homicide determined 28e. Place of Injury -	At home, farm, sti ipecify)	reet, factory, office		28f. Location (St. City or Town		Rural Route Number,
	To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2								
	Hosp 4 hou Fune ely fi	edical	29a. Certifier 12 Certifying Physician: To the best of m 2 Medicel Examiner: On the basis of examiner	amination and/or in	th occurred at the till Ivestigation, in my o	me, date and place opinion, death occu	, and due to the ca rred at the time, da	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To the within 2 To the complet	Med	one) and manner stated.  29b. Signature and title of certifier		29c. Licens	se number	2	9d. Date signed (Mo	nth. Dav. Year)
	T W I		Bula			54841		11/1/0	
1	101					) -1 - 1		/ /	
1	N		30. Name and address of person who completed cause of death			3.4	a		
7			9114 Philadel 31. Date filed (Month, Day, Year) 32. Regularists  MTV 0 2 2005	phia Ro Signature 4	ad Balt	imore M	u		
	Sta Regist		NOV 0 2 2005	Bed St. 8	SPORME				

State of Maryland / Department of Health and Mental Hygiene Reg. No. U Certificate of Death 1. Deçedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 1-Do wel Octoba 26 aomi 2000 /Medical 4c. County of Death 4a. Facility Name [If not institution, give-street and number] 4b. City, Town, or Location of Death Examiner Balhonere Modice N/A Center If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Days Min. 1 □ M 2 X F 087-36-3596 Oct 9, 1945 New York Director 60 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Howard Columbia Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7529 Murray Hill Road 21046 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Black þ 3 
 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. **Baltimore City Housing** Elementary/Secondary (0-12) College (1-4or 5+) Supervisor 12 other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be it of Health and Mental Grace L. Williams James E. Williams Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lisa Williams Daughter 140 East Ridge Circle Odenton, Maryland 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ŏ 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 2000. 11/01/05 Laurel, Maryland 4 Donation 5 Other (Specify) Maryland National Park Cemetery 21. Signature Funeral Service Liee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. De not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart/failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Pinal disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 2 No 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient ဥ 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manpér of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death. To the Funerel Director: A investigation 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 295. Signature and title of certifier 29c. License number October 26, 2005 1. I homes MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maryland 21202 Ba Paul Street Homove 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 0 2 2005 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryland	d / Department of Certificate		lental Hygie	Z U U D	35410
	Physici		1. Decedent's Name (First, Middle, La	mundell			2. Date of Death Month	Day Year	3. Time of Death 5:55 AM
	/Medic Examir		4a. Facility Name (If not institution, given which will be the state of M			n, or Location of Death		4c. County of Death	
	Funeral Director		212-24-9335	Sex 7. Age (In yrs. II	yrs. If Under 1 Y Months Da	ear If Under 24 Hrs. Lys Hours Min.	8. Date of Birth (Month, Day, Y	ear 29 Soun	lace (State or Foreign
	Maryland f show	tor	Usual Residence of Decedent  10a. State  10b County	Trundel (6) F	fown or Location			1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	death with the Maryland sms 23a or 28a-f show ir must be rediffed at	Funeral Director	10e. Street and Number	onCt	10f. Zip Co	076	10g	. Citizen of What Cour	etry?
20	iges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene.  If Item 27 is marked other then "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Eraminal must be retilised at	by Funera	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes, Give Year or Dates:	13. Was Decedent If Yes, specify  1 ☐ Yes 2 ☑	of Hispanic Origin? (Sp Cuban, Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
70-6171	filed within 72 hours after Hygiene. ther then "natural", or Ite ont, the Medical Examina	Completed	15. Decedent's Elementary Succession (9-12)	ducation	16a. Decedent's Usual O (Give kind of work d life. DO NOT use n	one during most of work		b. Kind of Business/Ind	ployfed
ומוומ ע	should be filed v nd Mental Hygie i marked other t umatic event, to	To Be Co	17. Father's Name (First, Middle, Las	" Edwar		18. Mether's Nam	e far	iden Sumame)	
, mary	and 2 sho ealth and N m 27 Is ma		Hable Fletch	(Type, Prifit) aughto	19b. Mailing Address (Se	affronc	t. Hano	reg Ad	20176
allimore	permit. Pages 1 ar Department of Hea Importent: If Item any injury or othe once.		`4 □Dopation 5 □ Other (Spec.	Removal from State	ace of Disposition (Name of American Company)	(outce) ///	4/85 F	c. Location - City or To	MA.
Da	permit. Pa Departmer Importent: any injury		21. Signature of Edneral Service Lige  23a. Part 1. Enter the disease, or cor	B. Oden S	22. Name and A	abeth An	e Salt	inore Mo	2/225 Approximate
	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	y one cause on each line.	icer	tyling, such as calculate	or respiratory arros		Interval Between Onset and Death
	Examiner	-6	Sequentially list conditions	b Due to (or as a consequ					
3/00,	be executed sician and buriat-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	ience of):				
O. BOX 08/	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnal 1	death 3 Ectopic pregr			23d. Date of delive	ery Day Year
as, r.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions	contributing to death but not resu	Ilting in the underlying caus	e given in Part I.		cco use contribute to the	
Vital Records	The tavate has	Completed					24a. Was an autopsy performe	prior to co	psy findings available mpletion of cause of 2 No
7115	Physicien: rthis certifica ral director, i	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 Impatient 2	ER/Outpatient 3□ DOA	Other	th (Check only one)	ce 6 □Other (Specif	(v)
lon or	ing Phy n. After this funeral d	atlon: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day Year)		Injury at Work?	28d. Describe how		,,
DIVISION	To the Hospitel or Attendir within 24 hours after death. To the Funerel Director: All completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		me, farm, street, factory, of	fice	28f. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,
	To the Hospitel or within 24 hours affe To the Funerel Dir completely filled in	edical	29a. Certifier 1 Certifying F (Check only one) 2 Medicel Exe	Physician: To the best of my know aminer: On the basis of examinat and manner stated.	wledge, death occurred at t tion and/or investigation, in	ne time, date and place, my opinion, death occui	and due to the cau red at the time, dat	se(s) and manner as s e and place, and due to	stated. o the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	groves mo	29c. L	16491	290	1. Date signed (Month,	Day, Year)
	3		30. Name and address of person who	Physician: To the best of my known aminer: On the basis of examinat and manner stated.  Groves moo completed cause of death (Item 195 22 5. Gr	123a) (Type, Print) Cene St B	altimore,	MD 21	201	- /
	St Regist	ate trar	31. Date filed (Month, Day, Year)  NOV 0 2 20	32. Registrar's Signal	ture				

1	220		For State Registrar	State of	Maryland / De	epartment o				ne 2005	354	11
	Physic	ian	1. Decedent's Name (First, Middl						ate of Death	Day Year	3. Time of D	Death
	/Medi	cal	Brandi Shaw		harl	4) 0) T		Oc	ctober	25 2005	1552	M
1	Examir	ner	4a. Facility Name (If not institution	_	oer)		m, or Location	of Death		4c. County of De		
	Funeral		Memorial Hospi 5. Social Security Number	6. Sex 7	. Age (In yrs. last birtho		ear If Under	24 Hrs. 8. Da	ate of Birth Month, Day, Y	Allegany 9. B	inthplace (State or	Foreign
75	Director		193-66-7211	1 □ M 2 💢 F	21 Yrs	Months Da	ays Hours	Min. (A	me 20,	1984 Mar	cyland	
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	r Location	-				10d. Inside City	Limite
	Maryl feho	Ď	PA Bedfo	ord	Bedfor						1 Tes 2	
	h the	lrec	10e. Street and Number		200202	10f. Zip Cod	de		10g.	Citizen of What C		
	ours after death with the Maryland rai', or iteme 23a or 28a-f ehow Examina must be molified	Funeral Director	1719 Cumberl	and Road		155	22			USA		
		nuel	11. Marital Status	Armed Ford	ent Ever in U.S.	3. Was Decedent If Yes, specify (	of Hispanic Or Cuban, Mexica	igin? (Specify Y	es or No-	14. Race - Am Black, Wh		
36	rs afte	by F	1 Mever Married 2 Married 3 Widowed 4 Divorced	If Vos Givo	X №	1 ☐ Yes 2 ☐ <b>X</b>				Specify: V		
9	72 hours after "natural", or ite	Completed by	15. Deceden	t's Education	16a. De	ecedent's Usual Oc	cupation		168	o. Kind of Busines	s/Industry	
215	thin 7	nple	Elementary/Secondary (0-12)	College (1-4	for 5+)	ive kind of work do e. DO NOT use re	tired)				,	
121	led will have the there there there is the the there is the the the there is the th		12		Med	dical Car				Mospital		
Maryland 21215-0036	ges 1 and 2 should be filed within 72 ho it of Health and Mental Hygiene if item 27 is marked other than "natur or other traumatic event, Ille Mudical	Be	17. Father's Name (First, Middle, Douglas B.					er's Name <i>(Firs:</i>		den Sumame)		
IZ.	should nd Me mark imatic	မ	19a. Informant's Name/Relations		19b. M	ailing Address (Str		ally A.		ity or Town State	Zin Code)	
	alth a		Sally A. Maust			9 Cumber						
ore,	es 1 a of Hea litem		20a. Method of Disposition		20b. Place of Di	sposition (Name or crematory or other		Date		. Location - City o		
Ĕ	Pag ment ant: it		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		010	ship Ceme		10-29-0	05 Be	edford, F	PA	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if item 27 ie any injury or other trau <u>pnce.</u>		21. Signature of Funeral Service	Licen ee	1	22. Name and Ad	dress of Facili	y Kight	Fune	ral Hom	ne	
	do z e d		23a. Part1. Enter the disease, or	300g /	J J	309-311	Deca	tur St	Cu	mberlar	Approximate	2150
8760,	Physician Medical Examiner physician and physician and the prijal-transit	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, it is a list of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	as a consequence of): as a consequence of): as a consequence of):	juries						
O. Box 6	The law requires that the death certifics ate has been signed by the ettending phage 2 should be delached for use as it	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown		h 2 Fetal death	3 □Ectopic pregna 5 □ Other (specify				23d. Date of de Month	elivery Day Ye	ar
rds, P.	w requires that been signed b should be dele	5	Part II. Other significant condition	ns contributing to dea	th but not resulting in th	underlying cause	given in Part I	. 2:	3e. Did tobaco		to the cause of dea	
Vital Records,	: The law recate has be page 2 sho	Completed							4a. Was an autopsy performed	? prior to death?	utopsy findings avacompletion of cau	ailable ise of
V. Its	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Other	of Death (Che				113
o		- T	1 X Yes 2 □ No 27. Manner of Death	1 □ Inp		JOIN JUDON				6 ☐Other (Spe	ecity)	
Division	To the Hospital or Attending Phywithin 24 hours after death. To the Funaral Director: After this completely filled in by the funeral of	Certification:	1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could r 4 Hemicide determ	g (Month,	Day Year) Injur	45 <sup>M</sup> 1	Nork?	No de	river	of mo	tor vehi	2
Ö	s afte	Cert	4  Homicide determ	building		reet		CI	o Town	ate)	Rural Route Numbe	
	To the Hospital or Attent within 24 hours after deall To the Funaral Director: completely filled in by the	edical	one)	and manne	est of my knowledge, de is of examination and/or r stated.	eath occurred at the investigation, in m	e time, date an iy opinion, dea	d place, and du th occurred at th	ie to the cause he time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)	
	To To	Σ	28b. Signature and title of certifier	•	Dag.		ense number CME			Date signed (Mon.		
	1/2	/	Malu y	ionila	Tollate.	اما	Donn C	root	Oct	ober, 26	, 2005 land 212	01
	5		30. Name and address of person	Amo completed cause	of death (Item 23a) (Typ	e, Print) LLL	Term St	reer l	рат с ТПК	re, rary	Lauu 414	O1
	Sta	te	31. Date filed (Month, Day, Year)	32" Reg	istrar's Signature	M42						
	Registr		NOV 0 2	2005 Rec	istrar's Signature							

			1 - State Registrar	partment of Health and N Certificate of Death	fental Hygier Reg. f	CHH5 .	35412
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Jayla M. Powell		2. Date of Death Month October 2.	2ay 2005	3. Time of Death 7:45 P M
	Examin Funeral Director		4a. Facility Name (If not institution, give street and number)  Anne Arundel Medical Center  5. Social Security Number  216-53-7264  6. Sex  1		8. Date of Birth	ar) Countr	ace (State or Foreign
	ס	or	Usual Residence of Decedent  10a. State  10b. County  Maryland Anne Arundel  Annap		pcp0 20		d. Inside City Limits
	th with the h	al Director	10e. Street and Number 18 Bens Dr. Apt. D	10f. Zip Code 21403	10g. (	Citizen of What Countr	
036	72 hours after death with the Maryland natural; or iteme 23a or 28a-1 ehow dical Examirat must be notified at	by Funeral	11. Marital Status    Marital Status   12. Was Decedent Ever in U.S.   1	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes XXNo Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Black, White, et Specify: Blac	tc.
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or iteme 23a or 28a-1 ehow any injury or other traumatic event, the Medical Examinat made to notified at once.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	ecedent's Usual Occupation live kind of work done during most of work e. DO NOT use retired) Student	Ge	Kind of Business/Indu	Éast
yland 2	ould be filed Mental Hygi arked other atic event, I	To Be Co	17. Father's Name (First, Middle, Last) Eric L. Boston	18. Mother's Nam Dorie I	e (First, Middle, Maid Powe11		
	s 1 and 2 sho of Health and item 27 is m other traum		Dorie Powell(Mother) 18	ailing Address (Street and Number or Rur Bens Dr. Apt. D	Annapoli	s, Md. 2	1403
Baltimore,	t. Pages 1 tment of He tant: if itan		4 Donation 5 Other (Specify)	Park 11-1	05 Ann	Location - City or Town	
Bal	permi Depa impor any ir		Larry S, Beese MO0983	Mm <sup>Name</sup> Re선생을 <sup>of</sup> & <sup>acili</sup> Sons 821 West St. Ann	apolis,	y, P.A. Md. 2140	1
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a nonsequence of):	enter the mode of dying, such as cardiac	or respiratory arrest,	11	Approximate interval Between Onset and Death
68760,	ficate be executed physicien and s the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):  d.				
O. Box	the death certi y the ettending iched for use a	Physician/Me		3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month D	/ Day Year
ords, P	w requires thet been signed b should be deta	Ď	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco	o use contribute to the 2 No 3 ☐ Probab	cause of death?
of Vital Records,	The law ate has b page 2 sl	e Completed	25. Was case referred to medical		24a. Was an autopsy performed?	prior to comp death?	sy findings available pletion of cause of
Division of Vit	To the Hospital or Attending Physician: I within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, p	Certification: To Be	examiner?	tient 3 DOA Cther: 4 Nursing Ho e of 28c. Injury at Work? TO M 1 Yes 2 No street, factory, office	Place to Check only one of the control of the contr		
	the Hospital nin 24 hours the Funeral npletely filled	edical	29a. Certifier (Clieux out) one)  1 Certifying Physician: To the best of my knowledge, de X Medical Examiner: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place, r investigation, in my opinion, death occurr	and due to the caused	(s) and manner as stat and place, and due to the	tod
),	dim d oo	×	29b. Signature and title of certifier  Mely Local Live  30. Name and address of person who completed cause of death (Item 23a) (Type	29c. License number OCME	Oc	Date signed (Month, Dectober 23,	2005
1	Sta		MARGORIOS A- KORELL		L DATCHIO	re, Marylaı	nd 21201
*<	Registr	ar	31. Date filed (Month, Day, Year)  32. Registrar's Signature				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 35413 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month PRICE TRAVES October 28 2005 10:45 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Wicomico Nursing Home Salisbury If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 22, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 ☐ M 2 🛛 F 89 Director Yrs 1916 Maryland 218-58**-**0459 Usual Residence of Decedent death with the Maryland 10a State 10h County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits other traumatic event, the Medical Exeminer must be notified at Director 1XXYes 2 □ No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 109 May Drive 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ŏ 1 ☐ Yes 2 🗓 No White þ Specify 3 X Widowed 4 □ Divorced natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within. Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Farmer Poultry 5 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Ward 2 Lena Parks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace R. Maddox (Daughter) 109 May Drive - Salisbury, Maryland 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from Stat injury or <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) Sunnyridae Memorial Park Nov. 1, 2005 Crisfield, Maryland 22. Name and Address of Facility
Bradshaw & Sons Funeral Home any ir Peth Braoshaw-Pruitt 306 W. Main St. - Crisfield, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2/2No

9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. the th Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. by 1 Yes 2 No 3 Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? RIENSION has autopsy performed? Yes 2 No StizUne DISORDER 1 ☐ Yes 2 No Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check on one) Hospital: 1 | Inpatient 1 ☐ Yes 2 No Other: 2 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 0060515 uncoller 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 614 Easternshore Dr Salisbury MD 21804 Maesha Thimmarayappa M.D. 31. Date filed (Month, Dav. Year) 32 Registrar's Signature NOV 0 2 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 5 per fth 9850 12-12-05 vt. State of Maryland / Department of Health and Mental Hygiene Reg. 2005 Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Physician Edward F Proctor 30 2005 <u>October</u> 9:00a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 802 Weatherbee Road Baltimore Baltimore County If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 214 18 1584 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□M 2□F X Yrs. Director June 8 1918 Washington D.C. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State : if item 27 is marked other then "natural", or itams 23a or 28a-f ehow or other traumatic event, the Mudical Examinar must be notified at 1 ☐ Yes 2 ☐ No Baltimore County Maryland Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 802 Weatherbee Road 21286 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ∐Yes 2 **∭**No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: ð 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within tent of Health and Mental Hygiene. Int: if item 27 is marked other then " College (1-4or 5+) Elementary/Secondary (0-12) 8 NAElectronics Technician ician Westinghouse
18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Edward F Proctor Sr Mary King 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Edward F Proctor III (Son) 802 Weatherbee Road Baltimore, Maryland 212% 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Meadowride Cemetary November 3 2005 Howard, Maryland 21. Smalure of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home Inc Mother 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 21236 shock, or heart failure. List only one cause on each line. Approximate
Interval 8etween
Onset and Death
2 years Immediate Cause (Final disease or condition resulting in death) Dementia Physician /Medical Due to (or as a consequence of): Examiner S - uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à tection 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 2 No 1 Yes Hospital or Attending Physician: After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death | Check only one examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ۵ 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending s after de-ral Director: Atte 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 29a. Certifier (Check only one) 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D55942 Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N. CHARLES ST #203 BALTIMORE MD 21201 IAUL N. FOSTER. 32. Pegistrar's Signature 31. Date filed (Month,-Day, Year) State Registrar NOV 0 2 2005

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			For Stata		aryland / De	partment of	Health ar	-		105	3541	5
_			Registrar		C	ertificate of	Death	10.000	Reg. No.	00		<u>U</u>
	Physicia	an	Decedent's Name (First, Middle, Last	t)	-	n	-	2. Date of Month	Day	Year	3. Time of De	
	/Medic		Flossie		L.	Pri		10	30	2005	2:p	М
	Examin	er	4a. Facility Name (If not institution, give		1		or Location of [	Death		unty of Death		
100	ACCEPTANCE OF THE PARTY OF THE	¥.	Lorien Frankford  5. Social Security Number 6. S		ge (In yrs. last birthda		timore	Hrs. 8. Date of	Birth	A 9 Birth	place (State or Fo	oreian
	Funeral Director			_M 252F	76 Yrs.	Months Day		Min. (Month,	Day, Year) 5-29	Cou	ntry) N.C.	, roigi
			Usual Residence of Decedent		70				5-25		IV.C.	
	yland how		10a. State 10b. County		10c. City, Town or						10d. Inside City L	
	a-f s	ctor	Md. NA		Ва	ltimore					1 <b>X</b> ]Yes 2[	_] No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizer	of What Cou	ntry?	
	23a	ral	5512 Frankford A			2120	-		1	USA		
	tems	nue	11. Marital Status	12. Was Decedent Armed Forces		<ol> <li>Was Decedent of if Yes, specify Cu</li> </ol>	Hispanic Origir Iban, Mexican, F	n? (Specify Yes or Puerto Rican, etc.)	No- 14.	Race - Ameri Black, White,		
36	s afte	by Funeral	1 ☐ Never Married 2 ☐ Married  3x☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Dates:	No	1 ☐ Yes 2 ☐ N	o Specify:		S	pecity: Bla	ack	
21215-0036	within 72 hours after death with the Maryland ane than "naturel", or items 23a or 28a-f show the Mudical Expriging must be mulified at		15. Decedent's Ed		16a. De	cedent's Usual Occ	upation		16b, Kind	of Business/Ir	ndustry	
15	n "n	plet	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or	(G.	cedent's Usual Occ ve kind of work don ). DO NOT use retii	e during most o red)	of working				
212	yiene.	Completed	12th grade	College (1940)		Domestic			Oth	er Peo	ple Home	į
	be filed within 72 hours after death with the Marylan hat Hygtiene od other than "naturet, or items 23a or 28a-f show od other than "naturet" spenified at event, the Markical Expenier mat be natified at	BeC	17. Father's Name (First, Middle, Last)					s Name (First, Mide	dle, Maiden Su			
<u>lar</u>	Mental Mental arked o	10 E	William	(	Cozart		G	Fracie		Smit	h	
Maryland	2 should be filed within and Mental Hygiene. is marked other than aumatic event, Ite M.		19a. Informant's Name/Relationship (	_		iling Address (Stre						
	ges 1 and 2 should t of Health and Men if item 27 is marke or other traumatic		Lonia Jones	Sister	and the second s	12 Frankf					21206	
ore	Pages 1 nent of H int: if ite iry or ott		20a. Method of Disposition  1 Spurial 2 Cremation 3	Removal from State	cemetery, o	position (Name of rematory or other p	lace)	Date	20c. Loca	tion - City or T	own, State	
Ē	Pa ant: ury		4 Donation 5 Other (Specif		Willia	ms Family		.1–5–05		tleton		
Baltimore,	permit. Pages 1 and 1 Department of Health Important: if item 27 eny injury or other tr once.		21. Signature of Funeral Service Licer	(47)	Company	22. Name and Add		110		ore, M		12
			23a. Part1. Enter the disease, or com	plications that cause	d the death. Do not	March F.			L E. No	rtn Av	Approximate	
			shock, or heart failure. List only Immediate Cause (Final	one cause on each	line.	•					Interval Between Onset and Dea	an ath
	Physician /Medical		disease or condition resulting in death)	a	s a consequence of):	ENTIA						
	Examiner				<b>a</b> 5011554 <b>a</b> 01165 017.							
	**	je.	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a consequence of):							
	cuted od ransit	Examiner	that initiated events	c								
760,	te be executed ysician and te burial-transit	EX	resulting in death) Last	Due to (or as	s a consequence of):							
976	eath certificate be executed attending physician and for use as the burial-transit	lcal		d							<del></del>	
89 x	fing p	Med	IF FEMALE;	22a Huga autaam	o of programmy							
Box	ath catternation	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic pregnar 5 □ Other (specify)			236	<ul> <li>Date of deliving</li> <li>Month</li> </ul>	rery Day Yea	ar.
P.O.	the death certifical y the attending phy Iched for use as th	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	at time of death	Offier (specify)						
	w requires that the deben signed by the should be detached	P.	Part II. Other significant conditions	contributing to death	but not resulting in th	underlying cause	given in Part I.	23e. D	id tobacco use	contribute to	the cause of deat	th?
sp	requires that een signed b hould be deta	Completed by						1	□ Yes 2 🖾	√o 3 □ Pro	bably 4 □Unk	(nown
00	w req	lete						24a. W		24b. Were aut	opsy findings ava	ailable
Re	The la ate hes page 2	mo						pe	s 22 No	death?	ompletion of caus 2□ No	se of
tal	sician: The law certificate hes b irector, page 2 s	a)	25. Was case referred to medical				26. Place 0	of Death (Check on		10,163	20110	
>	Physician: this certific ral director,	To B	examiner? 1 Tes 2 No	Hospital: 1 Inpat	ient 2 ER/Outpa	tient 3 DOA	Other: 4 Nurs	sing Home 5 R	esidence 6 [	Other (Spec	ıfy)	
0	ding Ph h. After th funeral		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Inj (Month, D	ury 28b. Tim ay Year) Inju		jury at fork?	28d. Descri	oe how injury o	occurred		
<u>io</u>	Attending or death.	satic	2 Accident investigatio			M 1	□Yes 2□No					
Division of Vital Records,	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of II	njury - At home, farm, etc. <i>(Specify)</i>	street, factory, office	e		n (Street and I Town, State)	Vu <i>mber</i> or Rui	ral Route Numbe	Γ,
	Hospital	0	29a. Certifier 1 Certifying Pl	veision. To the bee	t of my knowledge, d	anth annumed at the	time date and	place, and due to t	bo squee(s) es	d mannar as	olated	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ledical	(Check only 2 Medical Example)	niner: On the basis and manner s	of examination and/o	r investigation, in m	y opinion, death	occurred at the tin	ne, date and p	ace, and due	to the cause(s)	
	within To the	Me	29b. Signature and title of certifier				nse number			signed (Month		
	> 0		> Wiani	Om m	(1)	D	3510	2	Octo	ber 3	31,200	15
			30. Name and address of person who		death (Item 23a) (Ty					1		4.
_				and the same of th	5901 MG	vih CH	AVIRS	Striel	DAL	mor	e MAY	IAN
1	**************************************	ate	31. Date filed (Month, Day, Year) NOV 0 2 (		trair's Signature					l		Ĺ
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		1 - For State Registrar	State of Maryla	and / Depa		lealth and	Mental Hyg	piene 005	
es g es V	(a) (b)	1. Decedent's Name (First, Midd	le, Last)				2. Date of Dea	th	3. Time of Death
Physi /Med		Betty J. Parker	c .				Month October	Day Ye 31, 200	L.A
Exam		4a. Facility Name (If not institution	n, give street and number)		4b. City, Town, or	r Location of Dea		4c. County of E	
	*	Future Care Ch		_	Reisters			Baltimo	
Funera		5. Social Security Number	6. Sex 7. Age (In y.	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	1. (Month, Day		Birthplace (State or Foreign Country)
Directo	r	218-28-8957 Usual Residence of Decedent	72	115.			June 26	, 1933	MD
rland ow		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
ith the Marylar or 28a-f show	to	MD Balti	more Ou	ings Mi	11c				1 □ Yes 2 No
r 28a	irec	10e. Street and Number	more ow	Ingo mi	10f. Zip Code			log. Citizen of Wha	t Country?
h witi	al D	12 Cedarmere	Road		21117			USA	
If E, INIAL YIATION ZINIONO STANDON STAND	Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	ispanic Origin? (	Specify Yes or No-	14. Race - A	American Indian,
after of the state		1 Never Married 2 Mar	ried 1 Yes 2 No		1 ☐ Yes 2 ဩ No		nto riican, etc.)	Specify:	Vhite, etc.
hours af	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:			•		Зроспу.	White
127 r	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)	(Give	dent's Usual Occup kind of work done	during most of w	orking	16b. Kind of Busine	ess/Industry
Mithigh A	m d	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired	•		D = 1 1/	1 = -
Hygie nt.		10 17. Father's Name (First, Middle,	Last)	mea	t Wrapper		ame (First, Middle,	Food Mar	кет
d to fill He to other control of the tother	Be .	Monroe Denton S					ine Viola		
larytalla ZIZI 2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Ma	2	19a. Informant's Name/Relations		19b. Maili	na Address (Street a			r, City or Town, Star	
n 27 is			Grand Daughter					s MD 2111	•
Health tom 27 tom 27 tom 27		20a. Method of Disposition	200	. Place of Dispo	sition (Name of			20c. Location - City	
permit. Pages Department of I		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		•	matory or other place		/ 200F	r . 1	MD
artin injur	pit .	21. Signature of Euneral Service	, la		rem. Serv  2. Name and Addres			<u>Hampstead</u> eistersto	
g age	NIIFE.	1 5 6 1	1/2/11/ans	) <sub>E</sub>	line Fune	ral Home		eistersto stown MD	
7	3	23a. Part1. Enter the disease, o	r complications that caused the de						Approximate
Physician		mmediate cause (Final	t only one cause on each line.	1000/	thromb	2557			Interval Between Onset and Death
/Medica		disease or condition resulting in death)	Due to (or as a cons		TALLCHILL OF	7313			
Examine	r	Convention lies and disional	b						
n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):					
ate be executed hysician and the burial-transit	Examiner	that initiated events	C						
e exe	EX	resulting in death) Last	Due to (or as a cons	equence of):					
ate be ex hysician the burial	lical		d						
Attending Physician: The law requires that the death certificate reach.  Attending Physician: The law requires that the death certificate sector: After this certificate has been signed by the attending phys by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE:	020 16 100 01 100 01						
ath c	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pred 1 Live birth 2 F	etal death 3	Ectopic pregnancy			23d. Date of Month	delivery Day Year
the g	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time o	if death 5	Other (specify)				,
that the by detax	P.	Part II. Other significant conditi	ons contributing to death but not i	esulting in the u	nderlying cause give	en in Part I	23e. Did tol	bacco use contribut	e to the cause of death?
sign per per per per per per per per per per	d b)		Renal Disco		, , , ,				Probably 4 Dunknown
law requires I	ompleted by								· · · · · · · · · · · · · · · · · · ·
has has	mpl	1	on, Coronary	ALTEC	1 Disea	se,	24a. Was a autops perform	y prior	autopsy findings available to completion of cause of
Th Th	O	Diabetes Mo	<del></del>				1□ Yes	2 10 10 10 Y	res 2□ No
VICAL Sician: T certifical rector, p	o Be	25. Was case referred to medical examiner?	Hospital:		Othe		ath (Check only on		
Physical distribution	I   I	1 Yes 2 70	1 ☐ Inpatient 2	28b. Time of	f 28c, Injury			ence 6 Other (5	Specify)
Attending at death.  ector: Afte by the fune	ertification;	1 Natural 5 Pendi	ng (Month, Day Year,	Injury	Worl	k? Yes 2 □ No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Attendent death octor:	ifica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of Injury - A	t home, farm, str	eet, factory, office		28f. Location (SI	reet and Number of	Rural Route Number,
after after dinb	erti	4  Homicide determ	building, etc. (Spe	icity)	7.		City or Town		
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A tompletely filled in by the fu	ai	29a. Certifier 1 Certifyi	ng Physician: To the best of my k	nowledge, deat	h occurred at the tim	ne, date and plac	e, and due to the ca	ause(s) and manne	r as stated.
ne Ho 124 I	edicai	(Check only 2 Medical one)	Examiner: On the basis of exam and manner stated.	ination and/or in	vestigation, in my or	pinion, death occ	urred at the time, d	ate and place, and	due to the cause(s)
To the To the To the To the Comp	3	29b. Signature and title of certifie			29c. License			9d. Date signed (M	onth, Day, Year)
		> Karen a	R. Babitt, M.	D.	000	58676	- 1	wyember	1,2005
1(1)		30. Name and address of person	who completed cause of death (I	tem 23a) (Type,	Print)				
l <sup>u</sup>		Karen L. Bab.	H, M.D., 25 M	gin Str	eet, suite	200, 8	eisterst	own, M.	D 21136
	tate	31. Date filed (Month, Day, Year,							
Regis	strar	NOV 0	2 2005	H. A	and a				
DHMH 17 Rev 1	/2001		The state of the s						
				ORIGIN	AL				

Amend Item 23a per dr., 63.9,11/02/05/19. Red. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death RTHUR Month Year **Physician** RUCH CARL 5:35AM 2005 NOL /Medical 4b. City, Town, or Location of Death 4e Fecility Name (If not institution, give street and number) 4c. County of Death Examiner SYKESVILLE CARROLL BRINTON WOODS NURSING CENTER 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. 9. Birthplace (State or Foreign Sykes VILLE If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Min. Hours 1⊠M 2□ F 21832 3204 Director Usuel Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10a State 10b Count 1 ☐ Yes 2X No CARROLL SYKESVILLE Director mo 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 21784 USA BUCKHORN ROAD 1442 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours efter on the file of Health and Mantal Hygiene. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: δ 3. Widowed 4 □ Divorced White Completed Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Heavy DUTY EQUIPMENT MECHANIC RUCH MOTOR WORKS 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Meilke Beatha GEORGE 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 60 nt of Health a : If item 27 is or other trai /SISTER 707 LEE AVENUE SYKESVILLE MO MARGUERITE KNAUFF 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CARROLL CREMATION, FUL 11/2/2005 HAMPSTEAD, MD Separtment 22. Name and Address of Facility JNZUM BRUN FH& MONCO. 21. Signature of Funeral Service Licenses 6028 SYKESVILLE Rel ELDERS BURG MO 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) CHRONE RENDE FAILURES /Medical DIYR Examiner Examiner Consestive Heart Failure physician and s the burial-transit or Attending Physician: The law raquiras that tha daath certificata be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 K Unknown þ 24b. Were autopsy findings aveilable prior to completion of cause of deeth? **Completed I** 24a. Wes an autopsy performed? 2X No 1 ☐ Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: ٩ 1 ☐ Yes 2 No 1 🗆 Inpatient 2 ER/Outpatient 3 DOA 4KNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 5 Pending investigation 1 Natural 1 Yes 2 No death. 2 Accident i Director: / 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide hours aftar within 24 hours a

To the Funeral E

completely filled To the Hospital 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and the of certifier 29d. Date signed (Month, Day, Yeer) 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) ELDERSBURG UND URNOS LIBURTY KOAD 1000 32. Registrer's Signature 31. Dete filed (Month, Day, Year) State 2 2005 Registrar

		For Stete Registrer		of Marylar	nd / Depa <i>Cei</i>	artme <i>rtifica</i>	nt of H te of I	lealth a Death	ind M		Reg.		5	35418	
Physi /Med		Decedent's Name (First, Middle, La     JEANETTE CI	st) ECELIA	ROBINSO	ON				(	2. Date of Month Octobe			ear	3. Time of Death 3:30 a	
Exam		4a. Facility Name (If not institution, gir				4b. City	, Town, or	Location o	f Death			4c. County of	Death		
	Š.	918 N WOODINGTOR	RD.	7. Age (In yrs.	(act highday)		LTIMO	ORE	24 Hrs.	8. Date of	Righ	N/A	Dietho	lace (State or Fore	
Funera Directo		219-50-5323	1 □ M 2 🕏 F	5.7	V	Months		Hours	Min.	(Month,	Day, Ye	ar) L948	Cour	RYLAND	gri
and		Usuat Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							1	0d. Inside City Limi	its
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th the or 28a s.noti	Director	10e. Street and Number		1			ip Code				10g.	Citizen of Wh	at Cour	ntry?	
ath wi		918 N WOODINGTO	· · · · · · · · · · · · · · · · · · ·				212					U.S.A.			
ilied within 72 hours after death with the Maryland Hygiene. the than "natural", or Iteme 23s or 28s-f show ont, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed F	2 <b>∑</b> No live			edent of H ecify Cuba 211 No	ispanic Origin, Mexican, Specify:	gin? (Spe , Puerto	ecify Yes or Rican, etc.)	No-	Canaiha	Americ White,	etc.	
thin 72 hours at the "netural", or headlest Exam		15. Decedent's E	ducation		16a. Dece	dent's Us	ual Occup	ation during most	ot worki		16b	. Kind of Busi			
ithin 7	Completed	(Specify only highest gr Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT	use retired	during most ()	or worki	ng					
il Hygien other th		12th grade  17. Father's Name (First, Middle, Las	•1		CLER	K		18. Mothe	r's Name	/First. Mid		EALTH & den Sumame)	ME	NTAL HYG.	
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d 2 should the and Men 7 Is marketraumatic		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Addre	ss (Street					ty or Town, St	ate, Zip	Code)	
C 4 64 F		Howard A. Robinso	on, Sr/l		918 Place of Dispo	N. W	oodir	gton		Balt		Md., 2			
Store		20a. Method of Disposition  1 XBurial 2 Cremation 3		n State	cemetery, crer	natory`or	other plac	· 1				. Location - Ci			
permit. Page Department ( Important: If any injury or	4	4 Donation 5 Other (Spec		NE	22	Name	and Addres	s of Facility	v					ARYLAND	_
g age in	3	1/1/2	rolle	w				BROWN RTH AV			Y FU	INERAL	HOM	E P.A.	
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reate be executed physician and she burial-transit	dical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	C	o (or as a consec o (or as a consec											
	0	IF FEMALE:							-		-		11		
at the death certification by the attending I	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 0 0 9  Unknown	1 Live	utcome of pregn birth 2 Peta gnant at time of c nown	al death 3	Ectopic Other (	pregnancy specify)					23d. Date of Month		ary Day Year	
2 2 2	۾	Part II. Other significant conditions	contributing to	death but not res	sulting in the u	nderlying	cause give	en in Part I.			id tobacc	. 1.		ne cause of death?	۸'n
age age	Completed										utopsy erformed	? dea	or to co ath?	psy findings avaitat mpletion of cause o 2 No	ole if
Physician: The This certificate ral director, page	Be	25. Was case referred to medical examiner?	Hospital:				Oth	0.51		Check on					_
g Physical this neral di	n: To	1 ☐ Yes 2 ☐ No  27. Manner of Death	28a, Date	e of Injury	ER/Outpatier 28b. Time of		28c. Injun Wor	4 🗀 1401				6 Other		y)	
Attending in death.	atlo	1 Accident 5 Pending investigate	on .	nth, Day Year)	Injury	М		K? Yes 2 □N	No						
5 th to 5	Certification:	3 Suicide 6 Could not 4 Homicide determined	286. Plac	ce of Injury · At h ding, etc. (Speci	iome, farm, str fy)	eet, facto	ory, office				n (Street Town, St		or Rura	il Route Number,	
To the Hospital within 24 hours a To the Funeral is completely filled	Medical	29a. Certifier Check only one) Lectifying P	hysician: To the	ne best of my kni basis of examina finer stated.	owledge, deatl ation and/or in	n occurre vestigation	d at the tin	ne, date and pinion, deat	d place, a	and due to ed at the tir	the cause ne, date	e(s) and mann and place, and	er as s	tated. the cause(s)	
fo the vithin is o the	Mec	29b. Signature and title of certifier		anier stateu.		2	9c. Licens	e number			29d.	Date signed (	Month,	Day, Year)	
F 5 F 0		V/W/	M	7			DX	0655	10.6	5	N	1 vers ber	. 0	11, 200	5
		30. Name and address of pers of who	- 7	0	m 23a) (Type,	Print)		1 .1	4	7-	01		1	II, Zão	
N		31. Date filed (Month, Day, Year)	E de .	Registrar's Sign	ature U 7	versi	7.61	sayla	71	22	3. 1-1	ethe Ut		sulprire,	149
Regi	State strar	NOV 0 2	2005	SORLER A	K B	sell.									

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month L Wade Roach Sr 12:34 am <sup>™</sup> October 30 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs. B. Date of Birth
Months Days Hours Min.

Month, Day Year)

January 28 1935 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F 219 30 5870 70 Yrs Director Baltimore, Maryland Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location al Hygiene.
I chier than "natural", or itema 23a or 28a-f show the rhan "natural", or itema 23a or 28a-f show went, the Medical Examinar must be notified at 10d. Inside City Limits Director 1 Yes 2 No 134am Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 415 Meadow Road 21206 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/Α 6 Disabled N/A Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be in nent of Health and Mental is ant: If item 27 is marked o Louis Roach 2 Hattie Shifflet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) Catherine L Roach 415 Meadow Road Baltimore, Maryland 21206 item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Gardens of Faith Cem. November 2 2005 Baltimore, Mryland 21. Son Jure of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SND STAGE **Physician** disease or condition resulting in death) mouth a /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 3 Probably 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 200 No 1□ Yes or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA ō this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident Division 5 Pending investigation death. 1 ☐ Yes 2 ☐ No filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16601 N. Charles Sheet Boelto ND 21204 traulkner MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 2 2005

Registrar

			For State Registrar	State of Maryland	/ Department of Health and N	Mental Hygiene	005 251.20
	Physici /Medic		1. Decedent's Name (First, Middle )	i Chmond		2. Date of Death Month D-2	3. Time of Death 6:50AM
	Examin	er	4a. Facility Name (If not institution)	give street and number)	4b. City Town, or Location of Death Boll + inco	40.	County of Death
	Funeral Director	2	5. Social Security Number 16-28-3981 Usual Residence of Decedent	1	t birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show diesi Examiner must be rodiffed at	tor	10a. State 10b. County	10c. City, T	own or Location		10d. Inside City Limits V⊇Yes 2 ☐ No
	with the a or 28a-	by Funeral Director	10e. Street and Number		10f. Zip Code	10g. Citi:	zen of What Country?
	r death	ıneral	11. Marital Status	12 Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be rediffied at once.		1 Never Married 2 Marrie 3 Widowed 4 Divorced	d 1 □ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Black
215-0036	within 72 h ene. than "natu	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	16b. Kir	nd of Business/Industry
21	filed with Hygiene other thai		17. Father's Name (First, Middle, La	Lyeurs	18. Mother's Nam	e (First, Middle, Maiden	Sumame)
Maryland	nould be d Mental narked o	To Be	Richard You	NG	Hatti	e Doug!	ass
_	ss 1 and 2 sho of Health and item 27 is m r other treum	(	behorah A	Richmond F	19b. Mailing Address (Street and Number or Rui 5200 St. Georges	Ave, Ral	r Town, State, Zip Code) 6.112
Baltimore,	Pages 1 nent of He int: If iter iry or oth		20a. Method of Disposition  1 Daurial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe	Removal from State	e of Disposition (Name of etery, crematory or other place)  Memorial Factory	Date 20c. Lo	cation - City or Town, State
Balti	permit. Pag Department Importent: any injury o		21. Signature of Funeral Service Li		27 Name and Address of Easility	ye Fyres	Services
			23a. Part1. Enter the disease, or conshock, or heart failure. List on	omplications that caused the death. In one cause on each line.	Do not enter the mode of dying such as cardiac	or respiratory arrest,	Approximate Interval Between Inset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Congestive	Heart Failure		1999
	Examiner	er	Sequentially list conditions, if any, leading to immediate	b	nce of):		
16	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	nce of):	·	
8760	the the	cal		d			
.O. Box 6	death certif e attending d for use a:	Physician/Med	IFFEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ②No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deati	eath 3 Ectopic pregnancy	2	23d. Date of delivery Month Day Year
4	requires that the een signed by the	by	Part II. Other significant condition	s contributing to death but not resulting	ng in the underlying cause given in Part I.		se contribute to the cause of death?
Records,	~ Q TO	Completed				24a. Was an autopsy	24b. Were autopsy findings available
Vital Ro	The ate h	e Com	25. Was case referred to medical		Of Place of Dog	performed?	prior to completion of cause of death? 1 Yes 2 No
of Vii	S 5	To B	examiner? 1 ☐ Yes 2 ☑ No		VOutpatient 3□ DOA Other: 4□ Nursing He		
Division of	Attending Physicien: r death. sctor: After this certific by the funeral director.	atlon	27. Manner of Death  1 Atural 5 Pending 2 Accident investiga	(Month, Day Year) tion	8b. Time of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred
Divis	el or Atto s after de il Directo id in by t	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		e, farm, street, factory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number, )
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of my knowle caminer: On the basis of examination and manner stated.	edge, death occurred at the time, date and place, a and/or investigation, in my opinion, death occur	and due to the cause(s) red at the time, date and	and manner as stated. place, and due to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier		tordig 29c. License number DZ (	2702 1	e signed (Month, Day, Year)
	18			no completed cause of death (Item 23	Mysreland 11 any land 12 & Charles St Sunte 5105 B	altirou, mid	21204
	Sta Registi		31. Date filed (Month, Day, Year)  NOV 0 2 20	2 Registrar's Signature	Soul '		

ROBINSON

MABLE

State of Maryland / Department of Health and Mental Hygie $\eta$ e () 0.535421 For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:30 a Mable Robinson Oct 25, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Timonium Stella Maris If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days 1 □ M 2√□ F Yrs Director 250-16-3670 91 Jul 15, 1914 So. Carolina Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 7 is marked other than "naturel", or items 23e or 28a-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No **Baltimore** Director Maryland N/A 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? death with U.S.A. 3529 Liberty Heights Avenue 21215 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than "naturel", or Ite 1 ☐Yes 2 No 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🖫 No Specify: Specify: Black δ If Yes, Give Year or Dates: 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Someone Else's Home **Domestic Engineer** 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hattie Shaw Samuel Shaw ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7272 Longmont Loop Castro Valley, California 94552 Madeline Majete injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 11/01/05 Windsor Mill, Md. King Memorial Park 21. Signate Funeral Service Licens 22. Name and Address of Facility any ir Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ETZ 510725 (U)21 -1/5515E **Physician** /Medical Due to (or as consequence of): **Examiner** 2710 34 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-trans death certificate be exec Due to (or as a consequence of) attending physician Physician/Medicai as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ρ Month Yea Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed by Part II. Other Eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes No Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director: After or Attending 2 Accident 5 Pending investigation 1 Yes 2 No death. 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospitel within 24 hours a Commying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the ! the of certifies had 29d. Date signed (Month, Day, Year) 29b. Signature at 10/25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDDIE NAKHUDA, 2300 DULANEY VALLEY ROAD M.D.TIMONIUM, MD\_21093 31. Date filed (Month, Day, Year) 32. Regisfrar's Signature State Registrar

			1 - For State Registrar	State of Marylar		artment of H			iene	5 354	22
	Physici	20	1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of I	Death
	/Medic		Mary Rose	Sutherland				October	29 20	05 2:39	Α <sup>M</sup>
4	Examir	er	4a. Facility Name (If not institution, give s	street and number)			Location of Death		4c. County o		
			8434 Park Road  5. Social Security Number 6. Sep	7. Age (In yrs.	last birthday)	If Under 1 Year	sadena If Under 24 Hrs.	8. Date of Birth		e Arundel	r Foreign
	Funeral Director			M SINE	81 Yrs.	Months Days	Hours Min.	(Month, Day, April 3(	Year) 1924	<ol> <li>Birthplace (State or Country)</li> </ol>	r or orgin
	pu ,		Usual Residence of Decedent  10a, State 10b, County	40.00			-				
	shov	à			ty, Town or Lo					10d. Inside City 1 ☐ Yes	•
	28a-f	Director	Maryland Anne A	runder		10f. Zip Code	asadena	16	og, Citizen of Wi		
	3a or	0	8434 Park Road				1122	"	US		
	death	Funeral		12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-	14. Race	- American Indian,	
98	or Ite		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2X No If Yes, Give		1 ☐ Yes 2X No	Specify:	rican, etc.)	Specify:	, White, etc. White	
Ö	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show edical Examir ar marke redified at	ed by	3 Widowed 4 Divorced  15. Decedent's Edu	Year or Dates:	162 Door	dent's Usual Occupa					
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nd	be filed within 72 ho ital Hygiene id other than "natur event, the Medical	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			)	
<del>y</del> a	2 should be f n and Mental h is marked of raumatic ever	70	Thomas Pede				Pauline				
Mar	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty			ng Address (Street a				tate, Zip Code)	
ē,	Health tem 27 other tr	1	Dawn Hegarty ( 20a. Method of Disposition	Niece)	Place of Dispo	Park Roasition (Name of		Date 2		ity or Town, State	
JO I	0 0		1 XBurial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State		natory or other place oln Cemete	· INTIV	01		d, Marylan	d
Baltimore, Maryland 21215-0036	구두다는		21. Signature of Funeral Sovice Lichs	A /		. Name and Addres	2 , 20	00		ral Home,	
ä	permi Depar Impo		I dyd. y	7.1.		3111 M	Mountain				· · · ·
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oʻ	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):						
8760,	4 4	Physician/Medical									
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Вох	atten atten I for u	cian	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3□	Ectopic pregnancy Other (specify)			23d. Date Monti		'ear
0	at the de by the a stached	hysi	1  Yes 2 No 9  Unknown	9□ Unknown							
S, P	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	by P	Part II. Other significant conditions cor			nderlying cause give	en in Part I.	23e. Did toba	acco use contrib	oute to the cause of de	ath?
ord	w require been sig should b	ted	Congestive	Heart	Fa	Hure		1 X Yes	s 2□No 3	Probably 4 U	nknown
of Vital Record	e taw r has be se 2 sh	Completed						24a. Was an autopsy	pri	ere autopsy findings a or to completion of ca	vailable luse of
al H								perform 1 Yes 2		ath? ☐Yes <b>¾</b> ☐ No	
Vit.	Physician: T this certificat ral director, pa	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:	FB(0	• 3 DOA Othe	26. Place of Death				
	g Physier this	-	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury	at Nursing Ho	28d. Describe how	nce 6 Other		
ion	E & E	atlo	1 SNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	M 1 🗆 Y	res 2 □ No				
Division	after death, after death, I Director: After d in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, str	eet, factory, office		28f. Location (Stre City or Town,		or Rural Route Numb	) <i>01</i> ,
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	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier  (Check only one)  12 Certifying Physical Examination  2 Medical Examination	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or in	n occurred at the tim restigation, in my op	e, date and place, pinion, death occurr	and due to the car ed at the time, da	use(s) and manr te and place, an	er as stated. d due to the cause(s)	
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			Jan Land	~~~	MD	D	51591	0	dober	31 200	5
			30. Name and address of person who co	mpleted cause of death (Item	1 23a) (Type,	Print)	2004 6	1 0	- 41.4	31 200. 1021061	
		li e	17. Ambalavan 31. Date filed (Month, Day, Year) NOV 0 2 21	22 Panietrare Signa	UCIC	wood I	road (	nien But	nie in	1021061	
	Sta Registr		NOV 0 2 20	32. Registrar's Signa	All Sty						

			1 - For State Registrar		State	of Maryla	and / Depa <i>Ce</i>	artment rtificate				,	giene	000	351.23
残	4/4		Decedent's Name (First,	Middle, L	ast)							2. Date of De	ath	000	3. Time of Death
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	Examin		4a. Facility Name (If not inst	itution, gi	ive street and n	ımber)		4b. City, To	own, or i	Location	of Death		4c.	County of Death	
			Johns Hopkin							nore				N/A	
	Funeral		5. Social Security Number	1	Sex 1 ☐ M 2√2 F	7. Age (In yi	rs. last birthday) Yrs.		Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	h y, Year)	9. Birthr	place (State or Foreign
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	yland		10a. State 10b. C			10c.	City, Town or Lo	ocation						1	IOd. Inside City Limits
	Mar-	to	Maryland Ba	altin	nore		Dundalk								1 ☐ Yes 2√ No
	or 28	by Funeral Director	10e. Street and Number				DUIMAIN	10f. Zip C	ode				10g. Citi	izen of What Cour	ntry?
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	teme Brr	Jue	11. Marital Status		Armed F		U.S. 13.	Was Deceder	nt of His	panic Ori	gin? (Spe	ecify Yes or No Rican, etc.)		14. Race - Americ Black, White,	
36	s afte	y F	1 Never Married 2 3 Widowed 4 Div	•	If Yes, G	2 No		1 ☐ Yes 2 ☐		Specify:		, ,		Specify:	010.
8	tural	ed t			Year or I	Jates:	162 Doop	dent's Usual (	Ossunst	tion			105 10	Whi	
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or iteme 23s or 28s-f show the Madical Examiner must be notified at	Completed	(Specify onty	highest gi	rade completed		(Give	kind of work DO NOT use	done du	urina mos	t of worki	ng	16b. Ki	nd of Business/In-	dustry
212	yiene.	ШО	Elementary/Secondary (0 12	-12)	College	(1-4or 5+)	Cle		ĺ				C+	eel	
Þ	othe othe	Be C	17. Father's Name (First, M.	iddle, Las	it)			-1		18. Mothe	r's Name	(First, Middle,			
la	uld by Menta rrked ritic en	To E	Raymond	J.	Re	ynolds				Na	omi	т.	Raı	1	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iteme 23a or 28a-1 show any injury or other traumatic event, Ite Medical Examinar must be notified at once.	i 35	19a. Informant's Name/Rela	ationship	(Type, Print)		19b. Maili	ng Address (S	Street an	nd Numbe	or Rura	l Route Numbe		r Town, State, Zip	Code)
	and and m 27		Roy A. Sauer		(Husba	nd)	3468	Logan	view	v Dri	ve D	undalk,	MD	21222	
ore	of H of H if iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crema		·	20b	. Place of Dispo cemetery, crei	matory or other	er place,	,		ate		cation - City or To	•
Ē	Pagiment		4 □Donation 5 ☑ Oth	er (Speci	<b>沙</b> Entomb		Oak Law	n Ceme	tery	7	10/3	1/2005	Ba	altimore,	, Maryland
Baltimore,	permit Depar Impor Impor any in		21. Signature of Funeral Se	rvice Lice	ensee			2. Name and a				ome of	Dund	lalk Inc	7
	#10 7 6 Q		23a. Part1. Enter the disea	9										alk, Ind	· · · · · · · · · · · · · · · · · · ·
	Physician /Medical		shock, or heart failure Immediate Cause (Final disease or condition resulting in death)	List only	y one cause on	each line.	dio V	us cul	/		Ma	As C	Ay	res Ar	Approximate Interval Between Onset and Death
	Examiner		Conventially list conditions	- 1	b										
	70 ##	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	•	Due to	(or as a cons	equence of):								
	ficate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	1	c	,									
38760,	be ex ician burial	E	, , , , , , , , , , , , , , , , , , ,		Due to	(or as a cons	equence or):								
387	phys the	dicai		•	d								0.00		
_	⇒ 0. a	/Me	IF FEMALE:	. 1	23c. If yes, ou	itcome of preg	nancy							20.4 Date - 4.4-11	
Вох	w requires that the death cer been signed by the eltendir should be detached for use	Physician/M	in the past 12 months?		1 Live	birth 2 ☐ Fe nant at time of	etal death 3[	Ectopic preg					2	23d. Date of delive Month	Day Year
o.	the cather	hys	9 Unknown		9□ Unkr										
ري.	s tha	by P	Part II. Other significant co	nditions	contributing to	eath but not re	esulting in the u	nderlying cau	se given	n in Part I.		23e. Did to	bacco u	se contribute to th	ne cause of death?
ř	an sig	Ba	Dianes	ei	Melly	1,7		1	1			1 🗆 Y	es 2)	No 3 □ Prob	ably 4 □Unknown
Records,	aw re	Completed	Huller.	heras	12	/	Lu Dor	Line	1	101		24a. Was a	an	24b. Were autor	psy findings available
	The I	E	- 17/1			1 6	1	rijaci	V C	4		autop	med?	prior to cor death?	npletion of cause of
ta	ian: ntifica ctor. p	Bec	25. Was case referred to me	edical						26. Place	of Death	1 Yes	2/DNO	1 🗆 Yes	2   NO
<u>-</u>	Attending Physician: The laving death.  ector: After this certificate has by the funeral director, page 2	To	examiner? 1 ☐ Yes 25 No		Hospital: 1	Inpatient	ER/Outpatier	t 3 DOA	Other	-				Other (Specify	<i>'</i> )
u u	Attending Ph er death. rector: After th by the funeral	 	27. Manner of Death 1 Natural 5 ☐ P	ending	28a. Date (Mor	of Injury oth, Day Year)	2 b. Time of Injury	28c	. Injury a Work?	at	2	28d. Describe h	ow injury	occurred	
<u>s</u>	death.	cati	2 Accident	vestigatio				М		es 2 🗆 l	No				
Division of Vital	l or Attendate death after death Director: in by the	Certification:	4 Homicide	etermined	4 286. Plac	e of Injury · At ling, etc. <i>(Sp</i> e	home, farm, str	eet, factory, o	office		2	28f. Location (S City or Tow	treet and n, State)	d Number or Rura.	i Route Number,
_	To the Hospitel or A within 24 hours after To the Funeral Director Distriction of the Funeral Director of the Funeral Filled in by		29a. Certifier 12 Cer	difizio - C	huaista		1-1								
	24 ho Fun	Medical	(Check only 2 Me	dical Exa	miller. On the t	e best of my k pasis of exami oner stated.	nowledge, deatl nation and/or in	n occurred at vestigation, in	the time my opir	e, date and nion, deat	d place, a th occurre	and due to the o ad at the time, o	ause(s) late and	and manner as st place, and due to	ated. the cause(s)
	o the	Ā	29b. Signature and title of co	_	and mal	stateu.	~		icense r					e signed (Month, L	
	- s - ō		KS		14.11	de	DW	0	SOS	518	83		1	0/77/	01
	ļ		All Property and Park Street,		235 F 1	w Live	1	- /		- v •	-	-		~ 1 D//	<b>→</b> L
(a)	$\sim$	-	30. Name and address of pe	rson who	completed cau	se of death (It.	em 23a) (Type	Print)	-						, ,
6	W		30. Name and address of pe	rson who	completed cau			Print)	Bla	d	2	146	V & .	MO 7	1724

				For State Registrar	State of Mary	land .		rtment of H		nd Men		iene	005	35424
	S	I H I		Decedent's Name (First, Middle, Last)							Date of Deat	h Day	Year	3. Time of Death
		Physici /Medic			Michael	J.	Sliw	inski			ctober			11:05 A M
		Examin	er	4a. Facility Name (If not institution, give s				4b. City, Town, o		Death			ounty of Death	
	B.			Gilchrist Nursin 5. Social Security Number 6. Sex	g Ctr. 7. Age (In	yrs. last	birthday)	TOWSO If Under 1 Year	If Under 2	4 Hrs. 8. [	Date of Birth		1timor	place (State or Foreign
	C.	Funeral Director			M 2□F 82		Yrs.	Months Days	Hours		<i>Month, Day,</i> n • 9 <b>, 1</b>		Mar	yland
		, od		Usual Residence of Decedent		c Ciby T	own or Lo	nation .						10d. Inside City Limits
		within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28a-f show the Medical Examinar rust be indiffed at	'n			c. Oity, 1	OWIT OF LOC	ation						1 ☐ Yes 2XXNo
		28a-f	ecto	Maryland Balti  10e. Street and Number	more			10f. Zip Code	Dunda	alk	1	0g. Citize	in of What Cou	intry?
		with Sa or	וסו	8013 Gray Haven	beog				2122	2.2			nited	
		death ms 2;	nera		Was Decedent Ever     Armed Forces?	in U.S.	13. V	Vas Decedent of h Yes, specify Cub			Yes or No-	14	. Race - Amer Black, White	
	9	or Its	by Funeral Director	1 Never Married 2 Married	1 ☑ Yes 2 ☐ No		,	Yes 2 No		r dello riica	11, 610.)	s	pecify: Wh	
. \	5-0036	hours turel',	d b	3 ☑ Widowed 4 ☐ Divorced	Year or Dates: Ko	1		antia Havai Onova	ation					
10-2	15	"nat	Completed	15. Decedent's Educ (Specify only highest grade	completed)		(Give	ent's Usual Occup kind of work done OO NOT use retire	durina most	of working		IOD. NIIIC	of Business/l	lidustry
74	212	iene.	ошь	Elementary/Secondary (0-12) 9 Years	College (1-4or 5+)		Mas	ter Mech	anic			Fede	eral Go	vernment
1	p	other vent, I	Be C	17. Father's Name (First, Middle, Last)					18. Mother	's Name (Fil	rst, Middle, M	Maiden S	u <i>mam</i> e)	
	/lar	should be f and Mental I marked of umatic eve	To	Michael Sliwinsk	i					ıra Ko				
	Maryland	C1 10 - 00		19a. Informant's Name/Relationship (Type Mrs. Joyce A. Sch				g Address <i>(Str</i> eet 80 Shady			ute Number lefont			- 1
50	a)	1 and Health em 27 ther tr		Mrs. Joyce A. Sch 20a. Method of Disposition		Ob. Plac	e of Dispos	sition (Name of	Ī	Date	-		ation - City or 1	
-	mor	permit. Pages 1 ar Department of Hea Important: If Item: any injury or other ance.		1 ☐ Burial 2 ☑ Cremation 3 ☐ R	emoval from State	cem	etery, cren	ervice C		11/2/2			,	aryland
(2)	altin	artme ortani injury		4 □ Donation 5 □ Other (Specify)  21. Signature of P neral Service License		.) LITTT								
2	B	permit. Departr Imports any inje		de Redom	Keed		Du 79	Name and Address da-Ruck 22 Wise	Funera Ave.	al Hom Dunda]	e or 1 Lk, Ma	ryla	nd 21	222
		f ye		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the	death.							The A. A.	Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition	Reval	4	V.	1100					name of the control o	Onset and Death
U	*	/Medical		resulting in death)	Due to (or as a co	nsequer	nce of):	1						
		Examiner	١	Sequentially list conditions,	mult	20 Uar	e V	nyelon	na					Months
	41	pet	nlne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due 10 (0) as a cc	) 13 - Jue	100 01).	0						
	T	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a co	nsequer	nce of):							
3	760	pri pe	call											25/16/2000 1/2
र	99	as t		IF FEMALE:						<del></del>				
3	30	ath cert ttendin or use	Physician/Med	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐	]Fetal de	eath 3	Ectopic pregnanc	у			23	ld. Date of deli Month	very Day Year
-3	0.	he de the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tim 9□Unknown	e of deat	n 5∟	Other <i>(specify)</i> _						
5	٦.	ires that the d signed by the I be detached		Part II. Other significant conditions con	tributing to death but n	ot resulti	ng in the u	nderlying cause gr	ven in Part I.		23e. Did to	bacco us	e contribute to	the cause of death?
	rds	requires leen sign hould be	ed by								1 □ Ye	es 2	No 3□Pro	obably 4 Unknown
. ~	ecords	S S S	Completed								24a. Was a autops		24b. Were au	topsy findings available ompletion of cause of
25	$\mathbf{\alpha}$	9 <u></u>	E								perform		death? 1 ☐ Yes	
5	Vital	sician: Th certificate rector, pag	Be C	25. Was case referred to medicat examiner?						of Death C	heck only on	10)		1
3	of V	Physician: this certific al director,	2	1 ☐ Yes 2 No			VOutpatien	1 3 DOA		rsing Home	5 Reside		Other (Spec	MOSPIGE
(=		fter	lon	27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Ye	ear)	Injury	Wo	rk? ]Yes 2□↑		Describe III	ow injury	occurred	
10	Division	Attending r death. sctor: After y the fune	fical	3 Suicide 6 Could not be	28e. Place of Injury		e, farm, str						Number or Ru	ral Route Number,
4	Ö	alor/s after	Certification	4 Homicide	building, etc. (5	Specify)					City or Towi	n, State)		
		To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C		sician: To the best of m ner: On the basis of ex and manner stated	amination								
		To the within To the Comple	Me	29b. Signature and fittle of certifier	1			29c. Licen					signed (Month	
				MMan	llin	-		D 9	5830	03		CTO	nel:	21205
		10+1		30. Name and address of person who co	mpleted cause of deat	h (Item 2	3a) (Type,	Print)	1000	101 [	+ M	KCI	of Mr	212041
		- C 10		31. Date filed (Month, Day, Year)	AS, NO 32. Registrar's	Ul C	01	10.0	VEVL	ras o	1 101	130/	v	210-7
		St Regist	ate rar	11011 0 0	OOF JE HOUSING	Jignatul	ls i	and						
	DH	HMH 17 Rev 1/2		NUV U 2 Z	UUD PROGRAM	1000	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1							

		State of Maryland / Depa	rtment of Health and tificate of Death	Mental Hygie	2005	35425
\$7		Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
Physici /Medi		Hazel Lane Setzer		11-	01- 05	12.30P M
Examir	ier	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	ith	4c. County of Death	1.A
- Funeral	pt.	Franklin Square 1:050; for Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	1 Under 1 Year If Under 24 Hr	s. 8. Date of Birth	Baltimir 9. Birthpl	lace (State or Foreign try)
Director		238-10-0277 1□ M 20XF 84 Yrs.	Months Days Hours Mir	Feb. 24,	1921 N. Ca	vrolina
and		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Loc	cation		1/	0d. Inside City Limits
Maryl -1 sho	tor	Maryland Baltimore B	Baltimore			1 ☐ Yes 2 No
th the or 28a e noti	Director	10e. Street and Number	10f. Zip Code	. 10g.	. Citizen of What Coun	try?
er death with the Marylar Itema 23a or 28a-f show nat must be notified at	ralD	4005 Marjeff Place, Apt. F	21236		u.s.A.	
er de:	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No	Vas Decedent of Hispanic Origin? ( Yes, specify Cuban, Mexican, Pue	Specify Yes or No- into Rican, etc.)	14. Race - America Black, White, e	
036 urs aff	by	3 ☑ Widowed 4 □ Divorced Year or Dates:	☐ Yes 2 No Specify:		Specity: Whi	te
d 21215-0036 ified within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28s-1 show ont, the Medical Examinar must be notified at	Completed	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give I	ent's Usual Occupation kind of work done during most of wi DO NOT use retired)	orking 16I	b. Kind of Business/Ind	dustry
121 within see.	dmo	Elementary/Secondary (0-12)   College (1-4or 5+)	nemaker		Own Home	
Hale 212	Be C	17. Father's Name (First, Middle, Last)		ame (First, Middle, Mai		
faryland 212. Should be filed within and Mental Hygiene. Is marked other than reumatic event, its an event.	ToB	Harvey McCormick Brown	Mamie	Lewis		
re, Maryland 21, re, Maryland 21, st and 2 should be filed wit Hygient Health and Mental Hygiend them 27 is marked other the other treumatic event, the			g Address (Street and Number or F Morningview Circ			
2 C C C L and 1 and Health		20a. Method of Disposition 20b. Place of Dispos			c. Location - City or To	
Pages nent of ant: if the		1 □ Burial 2 (XCremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Rayview C		03/2005 Bo	ultimore. N	laryland
Baltimore, Me permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other treagues.			Name and Address of Facility So			
<b>o</b> 83558			705 Belair Rd.,			
\$ . M		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	er the mode of dying, such as cardia	ac or respiratory arrest,		Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)  a.   Neu monia  Due to (or as a consequence of):				
Examiner						
si:	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
760, be executed sicien and burial-transit	Examiner	c. resulting in death) Last  Due to (or as a consequence of):			-	
- <u> </u>	cal	d				
Box 68 leath certificat attending phy	Med	IF FEMALE:				
Box 68 Bot certifica attending ph	Physiclan/Med	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of deliver Month	ry Day Year
p.O. that the de ed by the detached	hysic	1 ☐ Yes 2 ☑No 9 ☐ Unknown	- Curo (apoony)			
S, P es tha igned l	by P	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.		cco use contribute to th	
Cord: w require been sig	eted	bronchiec tasis		1 🗆 Yes		ably 4 Unknown
Division of Vital Records, I or Attending Physician: The law requires taller cleath. Director: After this certificate has been signed in by the funeral director, page 2 should be	ompleted			24a. Was an autopsy performed	prior to con	osy findings available apletion of cause of
n: Ti	C	25. Was case referred to medical	26 Place of De	1 ☐ Yes 2 ☐ eath (Check only one)	No 1 ☐ Yes	2 No
f Vital nysician:	To B	examiner? 1 Yes 2 No Hospital: 1 patient 2 ER/Outpatient	Othor	Home 5 ☐ Residenc	e 6 ⊡Other (Specify	1)
On Of ding Phy h. After thi funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how	injury occurred	
VISIC Attend death ctor: y	flcat	2 Accident investigation 3 Suicide 6 Could not be determined determined	M 1 Yes 2 No	28f. Location (Stree	at and Number or Rural	l Route Number,
Div	Certification:	4 Homicide determined building, etc. (Specify)	,,	City or Town, S	itate)	
Hospit 4 hour Funer	edical (	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or inv	occurred at the time, date and place estigation, in my opinion, death occ	ce, and due to the caus curred at the time, date	e(s) and manner as stand place, and due to	ated. the cause(s)
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d.	. Date signed (Month, L	Dey, Year)
- 5 - 3		. J. M. sellet . Dhantle	D 3/0/060 3	M	overber 1	2005
L		30. Name and address of person who completed cause of death (Item 23a) (Type, I	D36663	1.11.	.11 1	2211
\( \) St		31. Date filed (Month, Day, rear) 32. Hadistrar's Signature	IN Square Drive	e Da Itimo	re, Md 21	231
Regist		NOV 0 2 2005	south)			

	1- For Amend Item 19a State of Maryland / Department of Health and M Certificate of Death	lental Hygieกู้ Reg. N	<b>2</b> 005 35426
	Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death
Physician /Medical	Kent Amos Showalter		31,2005 8.300 M
Examiner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	4	c. County of Death
	Batlimore-Washington Medical Ctr. Glen Burnie		Anne Andel
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 T Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea.	9. Birthplace (State or Foreign Country)
Director	Usual Residence of Decedent	2-13-1926	Pennsylvania
ylanc	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
e Mai	Maryland Anne ARundel GlenBurnie		1 ☐ Yes 2 🕅 No
or 28	10e. Street and Number 10f. Zip Code	"	Citizen of What Country?
6 after death with the Maryland or Itama 23a or 28a-f show culturer and be notified at Funeral Director	7869 Crilley Road 21060		ted States
ter de	11. Marital Status  12. Was Decedent Ever in U.S. Amed Forces?  1 Never Married 2 Married  12. Was Decedent of Hispanic Origin? (Specific Specific	Rican, etc.)	14. Race - American Indian, Black, White, etc.
036 036 036 036	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Xes, Give 3 □ XWidowed 4 □ Divorced		Specify: White
72 ho	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working)	16b.	Kind of Business/Industry
21215-00 led within 72 hou yolene. her then "nature it. I've Madical Et. Completed	Elementary/Secondary (0-12) College (1-4or 5+)		ormick & Co. Inc.
lied v		(First, Middle, Maide	
aryland aryland should be file should be file should be to should be file should be to should be file should be		May Shetr	
Showolftee $KENF$ Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygione.  Department of Health and Mental Hygione. Instruments of Health and Mental Hygione in The Transmeted other than "Instrumetic avent, the Maryled Examinet mast be recallified at once.  To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) George Showalter (brother)  19b. Mailing Address (Street and Number or Rura 1583 Bentley Cir. Bel		
other	20a. Method of Disposition 20b. Place of Disposition (Name of		Location - City or Town, State
Baltimore, semin. Pages 1 ar apparament of hear apparament of the may polytant: If the may polytant: of the bace.	1 Burial 2 Cremation 3 Hemoval from State 14 Donation 5 MOther (Specify) Entombment Meadowridge Mem. Pk 11-3-		ridge, Maryland
Bal Bal Bal Bal Bal Bal Bal Bal Bal Bal	21. Strature of Juneral Pervice Licensee  J. Wayne Osterling  22. Name and Address of Facility McCully-Polyniak Fun 237 E. Patapsco	neral Home Ave. Balt	, P.A. imore, MD 21225
A.*-	23a Pann. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or hear failure. List only one cause on each line.		Approximate Interval Between
Pnysician	Immediate Cause (Final disease or condition		Onset and Death
/Medical Examiner	Due to (or as a consequence of):		
<u> </u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
68760, fleate be executed physician and s the burial-transit edIcal Examiner	cause. Enter Underlying Cause Cleaneu or i juny that initiated events c.		
8760, cate be executed physician and the burial-transit dical Examir	resulting in death) Last Due to (or as a consequence of):		
68760, cate be exemply sician at the burial-cal Exemply sician at the burial-cal Exemply sicial	d		
x 6 entificing p	IF FEMALE:		
Box eath cert attendin for use.	23b. Was decedent pregnant in the past 12 months?  1		23d. Date of delivery  Month Day Year
P.O. nat the de deby the detached Physic	1 Yes 2 No 9 Unknown 5 Uner (specify)		
vision of Vital Records, P.O. Box 6 Attending Physician: The law requires that the death certificateath.  Crossalh.  To death.  By the funeral director, page 2 should be detached for use as death of the funeral director.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ord; en sig		1 ☐ Yes 2	2 No 3 Probably 4 2 Unknown
al Record  The law requir  aate has been s page 2 should		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Yeiclan: The tay yaiclan: The tay sis certificate has director, page 2		performed? 1 ☐ Yes 2 ☐ N	death?
Vital Fiden: The certificate ector, pag	25. Was case referred to medical examiner?  Hospital: Other: Othe		
Physic rethis cral direction : To	1 Paripatient 2 EH/Outpatient 3 DOA 4 Nursing Hor	ne 5 Residence 28d. Describe how inju	6 ☐ Other (Specify)
on of oding Phys. 1. After this funeral is	27, Manner of Death  1 Action 1 Sequence   28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?  2 Accident   Accident	200. 20001120 11011 111	ary occurred
Division of Vital Records, tor Attending Physician: The law requires that after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by	2 Suicide 6 Could not be	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number,
Division contending Parallel or Attending Parallel and Director Allert Illed in by the trineral Certification:			
Divisio  To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the tr	29a. Certifier (Check only one)  2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cause( ed at the time, date ar	s) and manner as stated.  nd place, and due to the cause(s)
To the within To the comp	29b. Signature and title of certifier 29c. License number		ate signed (Month, Day, Year)
	beleke kassahun M.D. DODJ5973	OL+	ober 31, 2005
20	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  2016 Desse 11500 Supperson hill Way Silv	ar com	ober 31, 2005
State	31. Date filed (Month, Day, Year) 32. Régistrar's Signature	Spr (r)	9
Registrar	NOV 0 2 2005		

			For State Registrar		Sta	te of N	/larylan		artment rtificate		ealth and	Mental H	/	1 tony	35427
4	sé.		Registrar     Decedent's Name	/Eirst Middle	(act)			Cei	lincate	OIL	Jeani	2. Date of D	Reg. No	,000	
6.	Physici /Medic		WELLING		_	LY						Month OCT	Da	Year 2005	3. Time of Death 0604 M
	Examin		4a. Facility Name (If		-				1		Location of Deat	h	40	County of Dea	th
			UNIVERSIT	-	ARY LAN				If Under		MORE If Under 24 Hrs.	10.0-1-15	N-At-	NA	
	- Funeral Director		5. Social Security No. 229–22–24	64	1 M 2		77	last birthday) Yrs.	Months	Days	Hours Min.	8. Date of E (Month, I	Day, Year) -28	9. Bin	thplace (State or Foreign buntry)  Va.
	and		Usual Residence of 10a. State	Decedent 10b. County			10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	Maryl f sho	ō	Md.	]	NA			Balti	more						1 X Yes 2 □ No
	r 28a	rec	10e. Street and Num	nber					10f. Zip	Code			10g. Cit	tizen of What Co	ountry?
	th with	alD	751 W.	Sarat	oga St	reet	Apt.	407		2120	01			USA	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other then "natural", or items 23a or 28a-f show or other treumatic event, the Mcdical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Marrie 3 □ Widowed	4.5	ed 1x	s Deceder ned Forces Wes 2 es, Give ar or Dates	] No		Was Deced f Yes, spec 1 ☐ Yes	ify Cubar	spanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No Rican, etc.)	10-	14. Race - Ame Black, Whit	
2-0	72 ho	eted		15. Decedent		ileted)		(Give	dent's Usua kind of wor	k done di	uring most of wor	rkına	16b. K	ind of Business	Industry
121	within ne.	Completed	Elementary/Secon	ndary (0-12)		lege (1-4o	r 5+)	life.	DO NOT us	e retired)		3			
	filed v Hygie other t		12th gra		(ast)			Sec	urity		ra 18. Mother's Nar	ne (First Midd		Smithsor	nian
Maryland	ould be t Mental I arked o	To Be	Bernard				Ç.	tutley			Alic		o, maioon		
ary	2 should and Men is marke	۲	19a. Informant's Na		nip (Type, Pri	nt)			ng Address	(Street a	nd Number or Ru		ber, City o		tus Zip Code)
	and 2 salth a n 27 is		Marcele	ne Stu	tely	Wif	е	75	51 W.	Sara	atoga St	reet, E	altir	more, Mo	a. <sup>Ap‡</sup> 1201 <sup>7</sup>
altimore,	es 1 and He of He riceth		20a. Method of Disp		3 Domova	I from Stat		Place of Dispo			)	Date	20c. L	ocation - City or	Town, State
Ē	Pag ment ant: I		4 Donation			i nom stat		Greenmo	ount (	Cem.	11-	5–05	4	timore,	
Balt	permit. Pages. Department of H important: If ite any injury or of		21. Signature of Fur	neral Service I	ll (	work	$\bigcirc$	.22	Name and		s of Facility  1. East			ore, Md. orth Ave	
#			23a. Part1. Enter th shock, or hear	ne disease, or t failure. List	complications only one caus	that cause se on each	ed the deat	h. Do not ent	er the mode	of dying	, such as cardiad	or respiratory	arrest,		Approximate Interval Between
4	Physician		Immediate Cause (I		a. C	HOLAN	GIOCA	RCINON	IA						Onset and Death
E	/Medical Examiner		resulting in death)			ue to (or a	as a conseq	uence of):							
	· `**	-	Sequentially list con	nditions,	b	lau to for a	ie a eoneco	ucoec offi-							
	uted d ansit	Examiner	dany, leading to im- cause. Enter Under Cause (Disease or i	rlying injury											
á	cate be executed physician and the burial-transit	Еха	that initiated events resulting in death) L		c.	ue to (or a	is a conseq	uence of):							
8760,	ite be iysicia ne bui	dical			d.									<u> </u>	
9	ng ph		IF FEMALE:		T										
P.O. Box	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	by Physician/Me	23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	months?	1 4	Live birth	ne of pregna 2 Feta at time of d	I death 3	Ectopic pre Other (spe					23d. Date of del Month	ivery Day Year
	w requires that been signed t should be det	ed by P	Part II. Other signifi	cant conditio	ns contributir	ng to death	but not res	ulting in the u	nderlying ca	iuse givei	n in Part I.			use contribute to □ No 3 □ Pr	the cause of death?
Division of Vital Records,		Completed										24a. Wa aut per 1 \sum Yes	opsy formed?	prior to death?	topsy findings available completion of cause of 2 No
Žį.	Attending Physician: Thir death. ector: After this certificate by the funeral director, pag	Be	25. Was case referre	,	Hospital	. /				Other	26. Place of Dea				
o	는 눈들	5 T	1 ☐ Yes 2 ☑ 1 27. Manner of Death			1 Inpa		ER/Outpatien 28b. Time of			4 Unuising n	ome 5 Res		6 □Other (Spec	cify)
OU	ding th. : After	tlon	1 ☑Natural 2 ☐ Accident	5 Pending	9	(Month, D	ay Year)	Injury	м	3c. Injury Work′ 1 □ Y	es 2 🗆 No	Edd. Dageribe	11011 111,01	y occurred	
Divisi	after dea Director I in by the	Certification;	3 Suicide 4 Homicide	6 Could n determi		Place of li building,	njury - At ho etc. (Specif	ome, farm, str	eet, factory,	office		28f. Location City or To	(Street an own, State	d Number or Ru	ral Route Number,
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one)	1 Certifyin 2 Medical t	examiner: Or	To the bes	of examina	wledge, death tion and/or inv	occurred a vestigation,	at the time in my opi	e, date and place inion, death occu	, and due to the	e cause(s) , date and	and manner as d place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and	title of certifier	1				29c.	License	number		29d. Da	te signed (Monti	n, Day, Year)
}			100	Muie	Jer	M	, M	り		P198	340		00	T 28,2	005
		25	30. Name and addre					1 23a) (Type, GREEN I		EET	BAIT	IMORE,			
	Sta	te	31. Date filed (Month				trar's Signa		J 18		10/101	1 10100			
	Registr			10V 0 2	2005	-	-	Att. A	and i	2					

ORIGINAL

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

NOV 0 2 2005

Murganite

82. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1111 Penn Street

1(OFB11

Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiepe Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Ann Louise Reider Scherr Oct 29 2005 7:28 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Joseph Ritchie Hospice If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, ) Sept 27, Birthplace (State or Foreign Country) **Funeral** 1□M 2XF 55 Months 219.38.6509 Director Yrs. PA Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Md Howard Columbia Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21044 USA 238 5014 Cloudburst Hill 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Yes No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrator 12 Columbia Association Pages 1 and 2 should be filed in nent of Health and Mental Hygid ant: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ira Reider <u>Katherine Handlev</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau Daniel Scherr- Husband 5014 Cloudburst Hill. Columbia, Md 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 11/3/2005 Falls Church, Va 22. Name and Address of FacilitWitzke 21. Signature of Funeral Service Licensee Funeral Homes Inc. \$555 Twin Knolls Rd. Columbia, Md 21045 tackma 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re-piratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Deset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Completed by Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use con to the cause of death? Records, 1 ☐ Yes 3 Probably 4 🗀 Unknown 24a. Wasan 24b. Were autopsy findings a prior to completion of au death?
1 ☐ Yes 2 P No rformed? 2 No of Vital To the Hospital or Attending Physician: 25. Was case referred to examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Wither (Speci Hospital: 2 (1 No 1 Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Mani of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation the Director: 3 🗌 Suicide 6 Could not b 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Momicide within 24 hours after To the Funeral Dire Dentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and 29d. Date signed (Month., Day, Year) 31. Date State Registrar

State of Maryland / Department of Health and Mental Hygienen 1 - Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 23, 2005 Frances Esther Treciak 08:24р м /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Greater Baltimore Medical Center Towson 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, 5. Social Security Number Funeral Birthplace (State or Foreign Country) 1□M 2□F Yrs. Director 215-18-7530 1923 July 20, Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ent If item 27 le marked other then "naturel", or Items 23a or 28a-f ehow 10b. County 10a. State 10c. City, Town or Location 7 le marked other then "naturel", or Items 23a or 28a-f ehow treumatic event, the Medical Examiner must ke notified at 10d. Inside City Limits Harford Director Fallston Md. 1 ☐ Yes X ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21047 U.S.A. 3106 Preakness Drive Funera 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: white Š 3 ₩idowed 4 Divorced Specify. Completed Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done do life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4or 5+) shipping clerk paper industry 8 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Marchuk Esther Kahler Hunter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther Treciak/daughter 3106 Preakness Drive, Fallston, Md. 21047 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
Department of t
Importent: If ite
any injury or of
once. 10/28/05 St. Stanislaus Cem. Baltimore, Md. <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 21. Signature of Juneral Service Ligenses 22. Name and Address of Facility Thomas Schimunek Funeral Home of Bel Air, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardiopulmonary Arrest 1/2 hour disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Month Congestive Heart Failure Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the burial-Box 68760. attending physician Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the by signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ icate has been sign. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖰 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2X No Division of Vital 1 🗌 Yes 2 No 1 Tyes Hospitel or Attending Physicien: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 🗷 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After s after dec. 1 X Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide in 24 hours. the Funeral Direction Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the complet 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D27437 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GBMC, 6701 N. Charles Street, Towson, Md. 21204 John Wogan, M.D., 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 2 Server 1 2005 Registrar

			1 - For State Registrar	State of	f Maryland /		artment of H		and M		giene () (	05	35431
	D		1. Decedent's Name (First, Middle	Last)						2. Date of Dea Month	th	Vant	3. Time of Death
	Physici /Medic		Celeste I	anielle T	ennell					October	Day 27 2	Yeer 005	12:43A <sup>M</sup>
i.	Examin		4a. Fecility Name (If not institution,	give street and nur	nber)		4b. City, Town, or	Location of	of Death		4c. County	of Death	
			14224 Angelton				Burton				Mont	gomer	-Y
	Funeral			6. Sex 1 □ M 2 1 F	7. Age (In yrs. last		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	<ol><li>Date of Birth (Month, Day)</li></ol>	Year)	9. Birthp	lace (State or Foreign otry)
	Director		094-56-9957 Usual Residence of Decedent		36	Yrs.				June 3	, 1969	New	York
	land ow		10a. State 10b. County		10c. City, T	own or Lo	ocation					1	Od. Inside City Limits
	Mary f she	ğ	MD Monto	omery	R.	urtor	nsville						1 X Yes 2 □ No
	r 28a	Director	10e. Street and Number			<u> </u>	10f. Zip Code				l0g. Citizen of \	What Cour	itry?
	3a o	I D	14224 Angelto	n Terrace			21	0866			USA		
	deatl	Funeral	11. Marital Status	12. Was Dece	dent Ever in U.S.	13.	Was Decedent of Hi If Yes, specify Cuba		gin? (Spec	cify Yes or No-	14. Rac	e - Americ	
9	after or Ita	F	1 Never Married 2 Marri		2 [XNo		37			(ican, etc.)		ck, White,	
93	raf,	d by	3 Widowed 4 Divorced	If Yes, Giv Year or Da	ates:		TU Yes 2KB NO	Specify:			Specify	r: Bla	ick
21215-0036	within 72 hours after death with the Maryland ene. than "netural", or Itams 23e or 28a-f show the Medical Examilier must be notified at	Completed	15. Decedent' (Specify only highes	s Education grade completed)	11	(Give	dent's Usual Occupa	lunng mos	t of workin	g	16b. Kind of Bu	usiness/Ind	dustry
2	within ne. han	шb	Elementary/Secondary (0-12)	College (1	-4or 5+)		DO NOT use retired	<b>,</b>					
2	iled v Tygie thar t		12th 17. Father's Name (First, Middle, L	2		Cus	stomer Se				Arbi Maiden Suman		
anc	ntal had of	Ве	Joseph Celest	· ·					la Ca		Maiden Suman	10)	
Maryland	hould Me mark mark matic	오	19a. Informant's Name/Relationsh		1	9h Mailir	ng Address (Street a				City or Town	State Zin	Code
Ma	id 2 s tth an 27 is trau		Ella Dunkley/M				24 Angelto						
Ğ	Heal Heal tam		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of	1			20c. Location -		
JO L	ages ant of it: If i		1X Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp		state		matory`or other place metery	· 1	11/5/	2005	Burtor	evil	le MD
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural; or Items 23a or 28a-f show amy injury or othar traumatic evant, the Medical Examiner must be notified at once.	l î	21. Signature of Funeral Service L		01120		2. Name and Addres						•
Ã	permi Depa Impo any it		Jamoro	A MOOK	M01103		313 Talbot					2070	
П			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that can	aused the death. D	o not ent	er the mode of dying	g, such as	cardiac or	respiratory arr	est,	-	Approximate Interval Between
	Pnysician	1	Immediate Cause (Final disease or condition	iny dis cause on o			Colon Car						Onset and Death
	/Medical		resulting in death)	a Due to (	or as a consequent		001011 041	1001					
١.	Examiner		Sequentially list conditions,	b. ———									
	p ii	Examiner	if any, leading to immediate cause. Enter Underlying		or as a consequent	ce of):							
	ecute and trans	cam	that initiated events resulting in death) Last	C		0							
8760,	cate be executed physician and the burial-transit	E	, , , , , , , , , , , , , , , , , , , ,	Due to (	or as a consequent	ce or):							
387		dlcal		d									
9 X	death certific e attending p ed for use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregnancy						22d Dat	e of delive	0/
Вох	atter after	ciar	in the past 12 months?	1☐Live bi	rth 2 🗍 Fetal dea ant at time of death	ath 3	Ectopic pregnancy Other (specify)				Moi		Day Year
o.	that the de ed by the detached	Physician/M	1 ☐ Yes 2 🚰 No 9 ☐ Unknown	9□ Unkno									
σ.	s that the ned by th e detache	by PI	Part II, Other significant condition	ns contributing to de	ath but not resultin	g in the ur	nderlying cause give	n in Part I.		23e. Did tol	oacco use conti	ribute to th	e cause of death?
Records,	The law requires ate has been signe bage 2 should be	pa								1 □ Ye	s XXNo	3 Prob	ably 4 DUnknown
000	aw requ s been 2 shoul	Completed								24a. Was a		Vere autor	osy findings available
	The lav	mo								autops perform	ned?   c	prior to con leath? 	npletion of cause of
Vital		Be C	25. Was case referred to medical					26. Place	of Death	(Check only on			
	d is	To	examiner? 1 ☐ Yes 2X No	Hospital: 1 🗆 II	npatient 2 ER/	Outpatien	t 3 DOA Othe	9r: 4 □ Nu	rsing Hom	e 5 🛣 Reside	ence 6 Oth	er (Specify	)
n of			27. Manner of Death 1 Natural 5 □ Pending	28a. Date of (Montal	f Injury 28th, Day Year)	. Time of Injury	28c. Injury Work	at ?	28	Bd. Describe ho	w injury occurr	ed	
Sio	Attanding r death. actor: After by the fune	catl	2 Accident investig	ation			M 1 🗆 Y	res 2□i	No				
Division	I or Attano after deatl Diractor: I in by the	Certification;	3 Suicide 6 Could n 4 Homicide determin	led 286. Place	of Injury - At home, ig, etc. (Specify)	farm, str	eet, factory, office		28	Bf. Location (St City or Town		er or Rural	Route Number,
	urs a												
	a Hospital 24 hours a Funaral I etely filled	edical	29a. Certifier 1f Certifying (Check only 2 Medical E	Physician: To the xaminer: On the ba and mann	isis of examination	ige, death and/or inv	noccurred at the time vestigation, in my op	e, date and pinion, deat	d place, ar th occurred	nd due to the ca d at the time, da	ause(s) and ma ate and place, a	nner as sta and due to	ated. the cause(s)
	To the Hospital or At within 24 hours after or To the Funeral Director Completely filled in by	Mec	29b. Signature and title of certifier	and matti	- statou.		29c. License	number		2	9d. Date signed	(Month, I	Day, Year)
)	->=o		So me to	XX 0.	, O		RESO	100			October	20	2005
	1/		30. Name and address of person v	no completed cause	of death (Item 23)	a) (Type.					oc rober	20,	2003
	0		Tanyanika Rein				y, Baltim	ore,	MD	21231			
	Sta	te	31. Date filed (Month, Day, Year)	32. Re	egistrar's Signature	£	A						
	Registr	ar	NOV 0	2 2005	Balana .	S.	a good of						

			1 - Statuend Item/11 pe	State of	Marylan 11/02/0	d / Depa Co	artmeni rtificate	t of H	ealth and Death	d Mental I	dygier	2005	351.32
			Decedent's Name (First, Middle, La							2. Date of	Death	W 9 0 0	3. Time of Death
	Physici		EUGENE		70	LIN	er			Month	2	Day Year	5 4:50 PM
	/Medio		4a. Facility Name (If not institution, given Genesis Healt)				4b. City,	Town, or Ltin	Location of D			4c. County of De	
arnor	Funeral Director		5. Social Security Number 6. 218-05-5121  Usual Residence of Decedent	\$9¥. 7 N∰M 2□F	'. Age (In yrs.	last birthday) 89 Yrs.	If Under Months	1 Year Days	If Under 24 H	lin. 8. Date of (Month)			rthplace (State or Foreign country) Maryland
3	h the Maryland r 28e-f show	= 1	10 0 1	oro		y, Town or Lo							10d. Inside City Limits
1	Be-f	ecto	laryranu barcim	ore	Da	TCIMO							1 ☐ Yes 2X No
lne	ath with the 23e or 2 ust be n	al Dire	3427 Parkfalls	Rd.			10f. Zip	2 1 2	236		10g. (	Citizen of What C USA	ountry?
of s	ours after death with ral', or Items 23e or Examiner must be	uner	11. Marital Status	12. Was Deced Amed Ford 1 N Yes 2	ces?	.S. 13.	Was Deced If Yes, spec	ent of Hi	spanic Origin? n, Mexican, Pu	(Specify Yes or lerto Rican, etc.)	No-	14. Race - Am Black, Wh	
5-0036	ours aff	d by F	3	If Yes, Give Year or Dat	es:W.W.	II	1□ Yes 2	<b>X</b> X <sub>No</sub>	Specify:			Specify: B	lack
215-(	nin 72 hours in "natural", Modical Ex	plete	15. Decedent's E (Specify only highest gr	ducation a de com <i>pleted)</i> College (1-4	Acr 5 1	16a. Dece (Give life.	dent's Usua kind of wor DO NOT us	l Occupa k done d e retired,	tion u <i>ring</i> most of	working		Kind of Busines	s/Industry eorge's Co.
2121	filed withir Hygiene. nther than ant, II e M	Com	12th	6yrs	401 34)		Teacl	her			Вс	ard Of	Education
land	should be filed within 72 hours after death with the Maryland and Mental Hygiene. In a Meryland in a	o Be (	10a. State  10b. County  Aaryland Baltim  10e. Street and Number  3427 Parkfalls  11. Marital Status  1 Never Married 2 Married  (Specify only highest gr  Elementary/Secondary (0-12)  12th  17. Father's Name (First, Middle, Last  Clarence Turne  19a. Informant's Name/Relationship	r) r						Jacks		en Surname)	
Maryland	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: if item 27 is marked other any injury or other traumatic event, <u>once.</u>		19a. Informant's Name/Relationship Randy E. Turne	Type, Print) r (Son)								y or Town, State, e, Md.	
Baltimore,	ges 1 a it of He if item or othe		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from Si		lace of Dispo				Date		Location - City o	
altim.	nit. Pa artmen ortant: injury e.		<ul><li>4 □ Donation 5 □ Other (Special</li><li>21. Signature of Funeral Service Lice</li></ul>		Ch	urch				-29-05		lenton,	
B	Depared Important in processions in procession in procession in procession in pro		Larry 11,1	Peese Mi	0048	3 8	m. Re 21 We	eese est	St. A	ns Mor nnapol	tuar is,	y, P.A Md. 21	401
	Physician		23a. Part1. Enter the disease, or con shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	pplications that can one cause en ear	used the deat ch line.	a. To	er the mode	e of dying	, such as card		y arrest,		Approximate Interval Between Onset and Death
38760,	Attending Physician: The law requires that the death certificate be executed or death.  Todath.  State this certificate has been signed by the attending physician and be performed to the funeral director, page 2 should be detached for use as the burial-transit or but the funeral director.	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	r as a conseq	a (Q uence of):	(	ar	C.N.	Ma			
P.O. Box 68760,	that the death certificed by the attending properties as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 □Feta nt at time of d	Ideath 3□	Ectopic pre Other (spe				-	23d. Date of de Month	olivery Day Year
	w requires that been signed b should be det	ed by Pl	Part II. Other significant conditions	contributing to dea	th but not res	ulting in the u	nderlying ca	use give	n in Part I.				o the cause of death? robably 4 MUnknown
Division of Vital Records,	The law requirate has been page 2 should	Completed								pe	tas an utopsy enformed? s 2/2/1	prior to death?	utopsy findings available completion of cause of
ital	ician: Th certificate rector, pag	Be C	25. Was case referred to medicat examiner?						26. Place of D	eath (Check on		10 10	2,6,110
<u>√</u>	Physic this ce al dire	2	1 ☐ Yes 2 No			ER/Outpatien			A N MULSING	JHome 5□R	esidence	6 □Other (Spe	ecify)
ono	nding Physician: th. : After this certific s funeral director,	tion:	27. Manner of Death  1 Natural 5 □ Pending 2 Accident investigation	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	M 28	3c. Injury Work 1 🗌 Y	at ? es 2 □ No	28d. Descri	oe how in	jury occurred	
Divisi	l or Attendi after death. Director: A I in by the fu	Certification:	3 Suicide 6 Could not be determined	289. Place 0	f Injury - At ho g, etc. (Specify	ome, farm, str	eet, factory,	office			n (Street a Town, Sta		ural Route Number,
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)  1 Certifying Plants (Check only one)	nysician: To the b miner: On the bas and manne	is of examina	wledge, death tion and/or inv	occurred a vestigation,	at the time in my op	e, date and pla nion, death o	ice, and due to to	he cause ne, date a	(s) and manner a nd place, and du	s stated. e to the cause(s)
	To th within To th compl		29b. Signature and little of certifier	HO11. (~	0106	. 51.		License			29d. D	ate signed (Mon	th, Day, Year)
	1/1		20 None and addition of	completed -		13/2/0	Point	U 5	368	7	0	c1	102005
7	X/7/		30. Name and address of person who A 2 rr & 4	2 22 (	or death (Item	) C/	Rail	19n	Bluck	303	B	e (timo	221239
	Sta Registr	ite ar	31. Date filed (Month, Day, Year) NOV 0 2 20	32. Reg	gistrar's Signa	ture	all so						

Shakis	sha 7	ľho	nas State State Unpend Item 23a,p						Mental Hy		_	35433
	\$ A.		1. Decedent's Name (First, Middle, Last)			lineate	OIL	Jealii	2. Date of De		000	3. Time of Death
F	hysici		SHAKISSHA	E.	THO	MAS	•		Octobe	r 28.	. 2005	02:22 A M
	Medic/ Examin		a. Facility Name (If not institution, give street and					Location of De			County of De	
			Good Samaritan Hospita	1,		Balt	imor	e				
C-1	uneral		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under Months	1 Year Days	If Under 24 H Hours Mi	n. (Month, Da	ay, Year)	9. B	irthplace (State or Foreign Juntry)
J Di	rector		Usual Residence of Decedent	28	Yrs.				JULY 12	7,197	7	MARYLAND
/and	ehow ad at		10a. State 10b. County	10c. City,	Town or Lo	ocation						10d. Inside City Limits
Man	28a-f eh	tor	MD	1	SAC	TIMO	RE	-				1 Yes 2 □ No
th the	or 28	Director	10e. Street and Number			10f. Zip	Code			10g. Citiz	zen of What (	Country?
ath w	23a	rai	813 DARTMOUT	H ROME	)						V.S.	H.
er de	ltem Dar II	Funeral	Ame	Decedent Ever in U.S. d Forces?	. 13.	Was Decede If Yes, speci	ent of His	spanic Origin? n, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	)- 	14. Race - An Black, Wh	nerican Indian, njip, etc.
)36 Irs aft	r, or	by F	If Yes	es 2.∭YNo ,Give orDates:		1□Yes 2	No No	Specify:			Specify:	SLACK
(1215-0036 within 72 hours after death with the Maryland	"netural", or Iteme		15. Decedent's Education		16a. Deced	dent's Usual	I Occupa	ation		t 6b. Kir	nd of Busines	s/Industry
215 Prin 7	Mad	ple	(Specify only highest grade completed [Specify only highest grade comp	ed) (1-4or 5+)	(Give lite. I	DO NOT us	e retired)	furing most of w	rorking		1, _	2.4.0.1
<b>N</b> 8 9	5.0	Completed	3			Cu	TRK.			`		RICAL
Ind De fil Ital H	marked other than matic event, the M	Be	17. Father's Name (First, Middle, Last)	Lomas				18. Mother's N	ame (First, Middle	, Maiden	Sumame)	/-C
arylan should be nd Mental	narke	L <sub>0</sub>		omins	405 14-15-		(0)		SHAKU	<b>~</b>	JUN	ES
0 2 2	2 €		19a. Informant's Name/Relationship (Type, Print)	10/10/14/	SILI	ng Address			Pural Route Numb		SON, State	
C =	itsm 27 other tr	1	20a. Method of Disposition	AND MOTHER) 20b. Pla	ce of Dispo	sition (Nam	e of		Date	_		or Town, State
Baltimore, bermit. Pages 1 al	= =		1  Burial 2  Cremation 3  Removal fr 4  Donation 5  Other (Specify)	om State cen	netery, crer 114-1111	natory or oth	her place	10/ 11-	3.05	her	namer	- HARVI AND
Baltimo permit. Pag Department	mportent: If eny injury or pncs.		21. Signature of Funeral Service Licensee	MU	22	2. Name and	Addres	s of Facility	ANGHAN	2.0	LEENE	FINISKAZ HON
<b>Ö</b> Eğ	eny ir	Ų	Vaufu A	une	4	905	Yor		AD BAC			
	240		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause	at caused the death,	Do not ent	er the mode	of dying					Approximate Interval Between
Phys	sician		Immediate Cause (Final	te Pyelone								Onset and Death
	edical		resulting in death)	to (or as a conseque	_	13	·					
EXA	miner	_	Sequentially list conditions, b.									
9	Sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to for as a conseque	ince of):							
60, be executed	sicien and burial-tran	xan	that initiated events c.	to (or as a conseque	nce of);							
760,	ysicien ne buria	calE										
687 tificate	g phys as the		a.									·
Box	attending phy	Physician/Med		outcome of pregnand		75				2	3d. Date of d	elivery
Geag	ed by the attendin detached for use	sicia	1 Dyes 2 No	ve birth 2 ∏Fetal d regnant at time of dea nknown		Ectopic pre Other (spe					Month	Day Year
P.O.	by the	h	9 to Onknown									
8 th	be d	þ	Part II. Dither significant conditions contributing	to death but not result	ing in the ur	nderlying ca	use give	en in Part I.		1	/	to the cause of death?
Orc requi	should should	eted	Spina Bifida						10	Yes 2	2 No 3 □ F	Probably 4 □Unknown
of Vital Records,	has b e 2 sl	Completed							24a. Was autor	DSV	prior to	autopsy findings available completion of cause of
1 4 4 1	icate r, pag									ormed? 2 ☐ No	death?	s 2 No
Vit	nis certificate has l i director, page 2 s	o Be	25. Was case referred to medical examiner?  1X Yes 2 □ No  Hospital:				Othe		eath Check only o		-	
Ph O	r this	$\vdash$	27. Manner of Death 28a. D	ate of Injury 2	R/Outpatien 8b. Time of		Sc. Injury Work	4   Nursing	Home 5 Resident			ecify)
ft.	: After the funeral	tlor	1 Natural 5 Pending (for a content of the content	Month, Day Year)	Injury	м		? ∕es 2 □ No		, , , , ,		
Division or Attending	ector: by the	1110	3 Suicide 6 Could not be 28e. P	lace of Injury - At hom	e, farm, str	eet, factory,	office					Rural Route Number,
Safe Die	ed Di	Certification:	4 Tromode	uilding, etc. (Specify)					City or To	wn, State)		
Division of Vital Records, P.O. Box 68 To the Hospitel or Attending Physician: The law requires that the death certifica within 24 hours after death.	To the Funarel Direc completely filled in by		29a Certifier 1 Certifying Physician: To (Check only (	the best of my knowl ne basis of examination	edge, death	vestigation	t the time	e, date and pla-	is, and due to the	date and	and manner t	IS Stated.
the t	the I	Medical	and r	nanner stated.								
T. with	To CO	<	29b. Signature and title of certifier			29c.	OCM	number E				nth, Dey, Year)
			Yanuty) outhout.	MD	–	_ 111	I D	Č-			er 28,	
			30. Name and address it person who completed of	ause of death (Item 2	(Type,	Print) 11	r Pei	шı stre	et Balt:	unore	, Mary	land 21201
green,	Sta	te	31. Date filed (Month, Day, Year) 3	Registrar's Signatur	re							
a sign	Registr		NUV 0 2 2000	Deve D.	Sou	nde						

			State Amend Item	State of 4a per ph	Marylan y G849	d / Depa	artment 15 tale	of H	ealth and N Death	Mental Hygi	iene	05	35434
	Physicia	an	Decedent's Name (First, Middle ALFRED)		D.			LIN		2. Date of Death	1	005 <sup>2</sup>	3. Time of Death 12:30 A M
	/Medic Examin	al er	4a. Facility Name of not institution Keswick Nursi	n, give street and numb					Location of Death			ty of Death	1
	Funeral		4100 N. CHARL  5. Social Security Number	6. Sex 7	#607 . Age (In yrs.	last birthday)	If Under 1		BALTIMO If Under 24 Hrs.		Voarl	9. Birth	N/A
	Funeral Director		131-14-7882	1 M 2□ F	8	Yrs.	Months	Days	Hours Min.	8. Date of Birth Month, Pay, SEP.28,	1924	Col	PA
	yland how		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo							10d. Inside City Limits
	ours atter death with the Marylar rei', or Items 23e or 28e-f ehow Examiner must be notified at	Director	MD N	/A		BALT	I MORE	Code		10	Og. Citizen of	What Co	1 XYes 2 No untry?
	th with	ai Dir	4100 N. CHARL	ES STREET	#607				21218				USA
	ltems rerms	Funerai	11. Marital Status 1 ☐ Never Married 2 【※ Mar	12. Was Deced	es?	.S. 13.	Was Decede If Yes, specif	ent of His fy Cubar	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- Rican, etc.)		ace - Ame ack, White	
3036	be tiled within 72 hours atter death with the Maryland tal Hygiene. d other then "neturel", or Items 23e or 28e-f ehow event, I'm Medical Examiner must be motified at	þ	3 ☐ Widowed 4 ☐ Divorced	Year or Dat	es: WW.		1 ☐ Yes 2		Specify:	1	Spec		WHITE
215-(	no 72 h n "netu Vedice	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	t's Education st grade completed)  College (1-	4or 5+)	(Give	<i>DO NOT</i> use	done d retired	uring most of won		16b. Kind of		
1212	iled with fygiene her the nt, to a	Com	17. Father's Name (First, Middle,	5+		STRUC	TURAL	ENG		ne (First, Middle, A			RTMENT
lanc	Abntal H	To Be	ISRAEL	LEGI		TOLI	NS		IDA				CKSTEIN
Baltimore, Maryland 21215-0036	s 1 and 2 should be tiled within 72 hc f Health and Mental Hygiene. Item 27 Ie marked other then "natur other treumettic event, the Medical		19a. Informant's Name/Relations MARJORIE TOLI							ra <i>l R</i> oute Number, T #607 <b>-</b>			ip Code) , MD 21218
e e	is 1 and of Health Itam 27 other tr		20a. Method of Disposition			Place of Dispo	sition (Name	e of			20c. Location		
timo	permit. Pages 1 and 2 Department of Health a Important: If Itam 27 le any injury or other tre-		1 X Burial 2 Cremation 4 Donation 5 Other (S	Specify)	BA				CEM 11/0				TOWN, MD
Bal	Depar Impol any ir		21. Signature of uneral Service	DCensee		8	900 RE	EIST	ERSTOWN	L LEVINS ROAD - P	UN & B IKESVI	LLE,	MD 21208
			23a. Part1. Enter the disease, o shock, o heart failure. Lis	r complications that ca	used the deat ch line.	h. Do not en				or respiratory arre	est,		Approximate Interval Between Onset and Death
0	Physician /Medical	5	Immediate Gause (Final disease or condition resulting in death)	a. Pur Due to (c	or as a conseq	ruence of):	vas	cul	and	sease			mayns
050	Examiner	L	Sequentially list conditions	b. Due to (c	or as a conseq	uence of):							
% S	cuted Id ransit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c		,							
09	ate be executed hysician and the burial-transit	icai Ex	resulting in death) Last	Due to (c	or as a conseq	uence of):							
4M 68760,	titicate ng phys as the	Medic		d.									
SO Box	that the death certiticate be executed ed by the attending physician and detached for use as the burial-transi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		ome of pregnath 2 Feta	al death 3[	☐Ectopic pre☐ Other (spe					ate of del Month	very Day Year
P.O.	at the de by the tached	hysic	1 Yes 2 No 9 Unknown	9□ Unkno	wn								
S,	Se De es	d by F	Part II. Other significant condit	nons contributing to del		^		Lise give	en in Part I.		oacco use co es 2 □ No		the cause of death?
ecord	aw requir is been si 2 should	Completed by	muelti-inf							24a. Was a autops		prior to a	topsy findings available
A Be	The ate h page									perform 1 Yes	ned? No	death?	2 □ No
> / F	S = 0	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 No	Hospital:	patient 2	ER/Outpatie	nt 3 DO	A Othe		th (Check only on ome 5 ☐ Reside		ther (Spe	cify)
NS 8		ion:	27. Manner of Death  1 Natural 5 Pendi	28a. Date o (Month	f Injury n, Day Year)	28b. Time o Injury	of 28	Bc. Injury Work	vat ⟨? Yes 2 □ No	28d. Describe ho	w injury occ	urred	
Z sisi	deall deall ctor: y the	Certification:	3 ☐ Suicide 6 ☐ Could	not be 28e. Place	of Injury - At h	ome, farm, st				28f. Location (St City or Town		nber or Ru	ıral Route Number,
0 0	Hospitel or A		29a, Certifier 1 Certify	ng Physician: To the			th occurred a	at the tim	ne, date and place	and due to the c	ause(s) and (	manner as	stated.
(6)	T 4 IT 0	Medical	(Check only 2 Medica one)	Examiner: On the ba and mann	sis of examina	ation and/or in	nvestigation,	in my or	pinion, death occu	rred at the time, d	ate and place	e, and due	to the cause(s)
	To the within 2 To the complet	2	29b. Signature and title of certification	on Day	0000	10	290.		564-2	1	90. Date sign		h. Day, Year)
Ω	18		30. Name and address of person	who completed cause	of death (Iter	m 23a) (Type	Print)	^	٥.	1/2.1		7 -	اعمط
E	) St	ate ·	31. Date filed (Month, Day, Yea,	allow Mi	of death (Item	ature N	.cvo	ule	o ova	T Call	0	ט ע	1007
N.	Regist		NOVO	2005	March A	J. 19							

			State of State of State of State of State of Registrar	Maryland / Dep <b>G849</b> 11-2-05	artment of F	lealth an	d Mental Hyg	iene	OFLOF
			Hegistrar  1. Decedent's Name (First, Middle, Last)		Timoate of	Death	2. Date of Deat	h	3. Time of Death
	Physici /Medic		GAYLE TEEGAND	EN .			Month	Day Year 2005	1230AM
	Examir		4a. Facility Name (If not institution, give street and num		4b. City, Town, o	or Location of D		4c. County of Deat	h
			LEVINDALE HEBREW HOME		BALTIMO		Mea	N/A	
п	Funeral Director		5. Social Security Number 6. Sex 1 M 2 7 F	7. Age (In yrs. last birthday, 64 Yrs.	Months Days	Hours 1	Hrs. 8. Date of Birth (Month, Day, 03/16/1	9. Birt	hplace (State or Foreign huntry) MO
			Usual Residence of Decedent	01		<u> </u>	05/10/1	J-11	P(1 110
	irylan show	_	10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
	88e-1 southie	ecto	MD N/A	BALTIM					1 Yes 2 No
	with t	Funeral Director	10e. Street and Number 2435 W. BELVEDERE AVENU	Г	10f. Zip Code 2121	E	10	Og. Citizen of What Co	untry?
	ns 23	era	11. Marital Status 12. Was Dece				? (Specify Yes or No-	U.S.A.	rican Indian,
9	ours after death with the Marylan et', or items 23e or 28e-f show Examinar must be notified at		Armed Fo  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes  If Yes, Giv	ces? 2 ☑ No	If Yes, specify Cuba 1 ☐ Yes 2 No		? (Specify Yes or No- ruerto Rican, etc.)	Black, Whit	
5-0036	i 72 hours after death with the Maryland "neturel", or items 23e or 28e-1 show sdical Examinar must be notified at	d by	3 Widowed 4 Divorced Year or Da	ites:	1 105 20 NO	Specify:		Specify: W1	
15-	"net	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of	working	16b. Kind of Business/	Industry
2121	filed within Hygiene. Nther then "	omp	Elementary/Secondary (0-12) College (1	-4or 5+)	KBINDER	۵/		PUBLISH	łING
٦	be filed Ital Hyg od othe event,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's	Name (First, Middle, N		
<u>ylaı</u>	e should be filed within and Mental Hygiene. Is marked other then sumatic event, the M	To	JACK H	TA	NHOFF	YETTA	Α	MIC	CHAELOVITCH
Maryland			19a. Informant's Name/Relationship (Type, Print)				r Rural Route Number,		
	1 and Health Iem 27 other tr		MARSHALL TANHOFF / BROT 20a. Method of Disposition	20b. Place of Dispo	osition (Name of		DAD-OWINGS Date 2	MILLS, MU 20c. Location - City or	
ПO	0		1 N Burial 2 Cremation 3 Removal from	state	matory`or other plac MUNO CONG	·	1/01/2005		
Baltimore,	그 문문을		21. Signal of Smeral Service Lic Asee				SOL LEVINSO		
m	permi Depa Impo any is		William Prug	ec 8!	900 REIST	ERSTOWN	N ROAD - PI	KESVILLE,	
			23a. Part1. Enter the disease, or complications that conshock, or heart failure. List only one cause on e	used the death. Do not en ach line.	ter the mode of dyin	ng, such as car	diac or respiratory arre	st,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	nd Stage 1	nultyle	seleco.	657		Onset and Death
	/Medical Examiner		Due to (	or as a consequalice of):	1				
		Jer	Sequentially list conditions, if any, leading to immediate b. Due to (	or as a consequence of):					
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events c.						
90	be executed sician and burial-transit		resulting in death) Last Due to (	or as a consequence of):					
8760	ate hy:	Physician/Medical	d						
Box 6	eath certific attending p	√/Me		come of pregnancy				23d. Date of deli	verv
B.	death e atte	Iclai	in the past 12 months?	ant at time of death 5	⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>	/		Month	Day Year
P.0	at the de by the stached	hys	9 □ Unknown 9 □ Unknown						
	The law requires that the tee has been signed by the bage 2 should be detache	by	Part II. Other significant conditions contributing to de	ath but not resulting in the u	inderlying cause giv	en in Part I.		acco use contribute to	,
Orc	w requir been si should	eted					- :	s 2 No 3 Pr	
Vital Records,	The taw cate has t page 2 s	Completed					24a. Was an autopsy perform	prior to d	topsy findings available completion of cause of
la 		e Co	25. Was case referred to medical			00 Pt/	1□ Yes 2	ZNo 1 □ Yes	2 No
<u> </u>	ysicie s cer direct	0	examiner?	npatient 2 ER/Outpatie	nt 3 DOA Oth		Death (Check only one ng Home 5 Resider	1	sify)
	ding Ph h. After thi funeral	Ju: T		f Injury 28b. Time o			28d. Describe hov		,
Sioi	Attending r death. sctor: After by the fune	catle	2 Accident investigation 3 Suicide 6 Could not be	, , ,,		Yes 2 □ No			
Division	ol or Attendi after death Director: A d in by the f	ertification;	determined 289. Place	of Injury - At home, farm, st. g, etc. <i>(Specify)</i>	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,
	urs ore ille	O	29a. Certifier 1 Certifying Physician: To the	best of my knowledge, deat	h occurred at the tin	me, date and n	lace, and due to the ca	use(s) and manner as	stated
	- C - E	edical	(Check only one) 2 Medical Examiner: On the ba	sis of examination and/or in	vestigation, in my o	pinion, death o	occurred at the time, da	te and place, and due	to the cause(s)
	To the vithin 2 To the complet	Ň	29b. Signature and title of certifier		29c. Licens	e number	29	d. Date signed (Monu	, Day, Year)
	N		> Thou mount		06	114		10/5/103	
3			30. Name and address of person who completed causi			0~ D	Wilhing	, MD	
	Sta	te.	31. Date filed (Month, Day, Year) 32, Re	-1-4 - 4- 014	bren Hon	nic) l	outhmore	70117	
	Registr		NOV 0 2 2005	was It fight	de				

	1- FoAmend Ite	m#8 per FH G8	Maryland Dep 52 273/06 Ce	artment of H rtificate of L	ealth an D <i>eath</i>		giene 0	5 35436
	1. Decedent's Name (First,	Middle, Last)				2. Date of De	ath	3. Time of Death
Physicia /Medica	Clara M. Utt	enreither				Month 10	28 2	Year 2005 7:15 AM <sup>M</sup>
Examine	4a. Facility Name (If not inst	titution, give street and numb	er)	4b. City, Town, or	Location of D	Death	4c. County	
	Stell Maris			Towson				imore
Funeral	5. Social Security Number	6. Sex 7. 1 ☐ M 2 💢 F	Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bir Min. (Month, Da	v, Year)	Birthplace (State or Foreign Country)
Director	215-09-6310 Usual Residence of Decede		93 115.			05/17/	1912	Maryland
yland	10a. State 10b. C	ounty	10c. City, Town or Lo	ocation				10d. Inside City Limits
Mar Mar	MD E	Baltimore	Baldwin					1 ☐ Yes 2 🙀 No
vith the Mar	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Country?
23a c	3 Palmway Co	ourt		21013			U.S.A.	
fter death	11. Marital Status	12. Was Decede Armed Force	ss?	Was Decedent of Hill If Yes, specify Cubar	spanic Origin n, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	- 14. Race	American Indian, White, etc.
urs afte	1 Never Married 2  3 Wildowed 4 Div	If Yes Give	-	1 ☐ Yes 2X No	Specify:		Specify:	
ba filed within 72 hours after death with the Maryland tral Hygiene. Id other then "natural", or tems 23e or 28e-f show event, if a Modical Exertion of the modical Exertions.		orced Year or Date		dent's Usual Occupa	tion		16b. Kind of Bus	White
ed within 72 ho ygjene. nar than "natur: it, II e Medice!	(Specify only	highest grade completed)	(Give	kind of work done d DO NOT use retired;	uring most of	working	100. Kind of Bus	siness/industry
d with	Elementary/Secondary (0	College (1-4)		memaker			Own Ho	ome.
ba file tal Hyg d othe evant,	17. Father's Name (First, Mi	iddle, Last)			18. Mother's	Name (First, Middle,		
should b nd Menta markad umatic e	Peter Kowal	ski			Unkno	wn Broki		
2 sho and Is ma	19a. Informant's Name/Rela	ationship (Type, Print)	19b. Maili	ng Address (Street a	nd Number o	r Rural Route Numbe	r, City or Town, S	State, Zip Code)
and and m 27 har tr	Tom_Brown_(	grandson)			Road -	Timonium,		
Datumore, Mary Janua 212.13-0030 parmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic event, its Modical Examinations and percentage.	20a. Method of Disposition 1 X Burial 2 ☐ Crema	ation 3 Removal from Sta	20b. Place of Dispo cemetery, crei	osition (Name of matory or other place	9)	Date	20c. Location - (	City or Town, State
Daltillo	`4 □Donation 5 □ Oth		Dulaney Val	ley Mem. Gan	s. 111	/01/2005	Timonium	n, Maryland
Darmi Depar Impo any ir	21. Signature of Funeral Se	$\mathcal{L}$						eral Home, P.A.
	23a. Part 1. Enter the diseas	se, or complications that cause				d - Kingsv		aryland 21087 Approximate
V	shock, or heart failure. Immediate Cause (Final	. List only one cause on each	line.	A 1	1	T		Interval Between
Physician /Medical	disease or condition resulting in death)	a. Due to (or	d- Stua	R 111	zhein	ner's	)1se as	e years
Examiner		South to (or	as a consequence of):		3			J
	Sequentially list conditions, 1 any leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (3r	as a nonsecuence of)					
executed an and rial-transit	that initiated events	С.				•		
cate be executed physician and the burial-transit	resulting in death) Last	Due to (or	as a consequence of):					
cate be exphysician the burial		d						
ding page as	IF FEMALE:	020 15 100 01400						
w requires that the death certific been signed by the attending p should be detached for use as	23b. Was decedent pregnar in the past 12 months?		2 Fetal death 3	Ectopic pregnancy			23d. Date Mont	of delivery th Day Year
the de	1  Yes 2 No 9  Unknown	9 Unknow	t at time of death 5	Other (specify)				
that the ed by detacl	Part II. Other significant co	nditions contributing to death	n but not resulting in the u	nderlying cause give	n in Part I.	23e. Did to	bacco use contril	bute to the cause of death?
quires that signed and be of						1 🗆 Y	es 2 No 3	3 ☐ Probably 4 ☐Unknown
w requ						24a. Was a	an 24b. W	ere autopsy findings available
Physician: The law requires that the death certificate has been signed by the attending ral director, page 2 should be detached for use as						<ul><li>autop</li><li>perfor</li></ul>	sy pr med? de	ior to completion of cause of eath?
ician: Th	25. Was case referred to me	edical			26. Place of	1 ☐ Yes  Death (Check only or		Yes 2X No
hysicia his cer	examiner? 1 ☐ Yes 2⊠No	Hospital: 1 ☐ Inpa	atient 2 EP/Outpatien	t 3 DOA Other	r	ng Home 5 Resid		(Specify)
ding Ph After th funeral	27. Manner of Death  Danatural 5 □ P	28a. Date of li (Month, I	njury 28b. Time of Injury	28c. Injury Work	at		ow injury occurre	
andii eath. or: A the fu	2 Accident in	vestigation			es 2 □ No			
tal or Attanding P rs after death. al Diractor: After t ed in by the funera		etermined 28e. Place of building,	Injury - At home, farm, str etc. (Specify)	eet, factory, office		28f. Location (S City or Tow		r or Rural Route Number,
To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	20a Cariffica >CO	diffusion Dh. 1.1.	.,					
tha Hospi in 24 hour the Funar pletely fill	29a. Certifier X Car (Check only 2 Mac one)	rtifying Physician: To the be dical Examinar: On the basis and manner	of examination and/or in	occurred at the time vestigation, in my opi	e, date and pl inion, death o	ace, and due to the cocurred at the time, or	ause(s) and man late and place, ar	ner as stated.  nd due to the cause(s)
o tha vithin o the omple	29b. Signature and title of co		\ 1	29c. License	number	2	29d. Date signed	(Month, Day, Year)
- ≤ - ŏ	> Dance	1	Localit	NC	577	40	Octol	00 28m 2005
	30. Name and address of pe	erson who completed cause of	f death (Item 23a) (Type	Print)			-CLOK	
0	ERNESTINE		2300 DULAN	•	ROAD	TIMONIU	UM MD	21093
State	31. Date filed (Month, Day,	V 1						
Registra	NO	10 2 2005	strar's Signature	S. D. C.				

OCTOBER 28, 2005

UTTENREITHER, CLARA

			For State Registrar	State of Marylan	d / Department of Hea		al Hygiene	35437
12	Physici	an	Decedent's Name (First, Middle, Last	0	1		te of Death	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Lor	cation of Death	tober 37, 20	005 19 30pm
	Examili	er	Greater Balt	more Medical	Genter Tows	son	Bal	timore
	Funeral Director		5. Social Security Number 6. Se			Under 24 Hrs. 8. Date Hours Min. (Mo	onth, Day, Year)	Birthplace (State or Foreign Country)
_			Usual Residence of Decedent			215110	12112005	Maryland
	ours after death with the Marylan ral', or Items 23a or 28a-f show Ext. illner i ust be in tilled	or	10a. State 10b. County	10c. Cit	y, Town or Location			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	th the or 28a-	Director	10e. Street and Number	-	10f. Zip Code		10g. Citizen of What	t Country?
	s 23a	eral	8 Castle t	ord Cou	rt 2134	14	USA	
9	after de or item	Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 No	If Yes, specify Cuban, N	Mexican, Puerto Rican, e	s or No- etc.) 14. Hace - A Black, V	American Indian, White, etc.
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-1 show ta Marical Existinati. Ast De traffical	ed by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No S	Specify:	Specify:	Black
215	be filed within 72 ho ital Hygiene. id othar than "natur avant, II e Musile	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	(Give kind of work done durin life. DO NOT use retired)		16b. Kind of Busine	ess/Industry
	e filed within I Hygiene. other then		17. Father's Name (First, Middle, Last)	0	Intant	T	Into	int
lanc	should be find Mental H marked of matic aver	o Be	Principle (First, Middle, East)	Un	decuraco T	Mothers Name (First,	Middle, Maiden Surname)	ect
Maryland	2 should and Men is marka aumatic	-	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing Address (Street and	Number or Rural Route	Number, City or Town, Stat	te, Zip Code)
	1 and Health am 27		20a. Method of Disposition	20b. P	lace of Disposition (Name of	265 5T, Date	20c. Location - City	or Town, State
<u>m</u>	Pages nent of int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	Removal from State	emetery, crematory or other place)	xy 11/1/200	6 6000 C	TTY M
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If Itam 27 is marka any injury or othar traumatic ance.		21. Signature of Funeral Service Licen	was a	22. Name and Addrass of	of Facility 15 A Son	on me ZIII	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the death	n. Do not enter the mode of dying, si	uch as cardiac or respira	atory arrest,	Approximate Interval Between
Æ	Pnysician /Medical	i vi	Immediate Cause (Final disease or condition resulting in death)	a Extrer	ne Kerrat	wity		Onset and Death  A hours
	Examiner		Commentally lies and distance	Due to (or as a consequent	uence ot):	.1		
	be isi	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Unitaritying Cause (Disease or injury	Due to (or as a consequ	uence of):			
oʻ	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequ	uence of):			
8760	cate be ex physician the burial	dlcal		d				
Box 6	death certifica attending ph d for use as t	υ/Meα	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna			23d. Date of	delivery
	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physiclan/Me	in the past 12 months?  1 Yes 2 No 9 Unknown	1 □Live birth 2 □Fetal 4 □ Pregnant at time of de 9 □ Unknown			Month	Day Year
P.O.	that the died by the detached		Part II. Other significant conditions co	entributing to death but not rest	ulting in the underlying cause given in	n Part I. 23e	e. Did tobacco use contribut	e to the cause of death?
Records,	w requires been signe should be	ted by					1 ☐ Yes 2 XNo 3 ☐	Probably 4 Unknown
3ecc	e law has b	ompleted				248	autopsy prior	autopsy findings available to completion of cause of
Vital B	ician: The certificate ha rector, page	O	25. Was case referred to medical		26	1) S. Place of Death (Check	yes 2 No 1 No	Yes 2□No
of V	Physician: this certific ral director,	To B	1 105 200	The state of the s	ER/Outpatient 3 DOA Other:		☐ Residence 6 ☐ Other (S	Specify)
ono	Attending Property.  Attention of the funeral of th	tlon:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury at Work?  M 1 ☐ Yes	28d. De:	scribe how injury occurred	
Division	il or Attendii after death. Director: A I in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, factory, office	28f. Loc. City	ation (Street and Number or	Rural Route Number,
0	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Attercompletely filled in by the funer		29a. Certifier 1 Certifying Phy	1	wledge, death occurred at the time, o	4	· · · · · · · · · · · · · · · · · · ·	
	tha Hos hin 24 h tha Fur npletely	edical	(Check only 2 Medical Examone)	iner: On the basis of examinal and manner stated.	tion and/or investigation, in my opinio	on, death occurred at the	e time, date and place, and	due to the cause(s)
	To tha within 2 To tha complet	Σ	29b. Signature and title of certifier	1 hour	29c. License nu		29d. Date signed (Mo	onth, Day, Year)
			30. Name and address of person who d	ompleted cause of death (Rom	123a) (Type, Print)	000	Uctober	38,2005
			Beth K. Sc	OWOVTZ M 32. Degistrar's Signa	D. GBMC	6701 N.	Charles S	t. mo alacy
:	Sta Registr		31. Date filed (Month, Day, Year)		ture from			

			1 - State State Registrar	e of Maryland		artment of I		nd Mental Hy	giene	11115	35438
	Physic	an	Decedent's Name (First, Middle, Last)  Toggode	Vone				2. Date of D Month	Day	Year	3. Time of Death
	/Medi Examir		Joseph  4a. Facility Name (If not institution, give street and	Vona		4b. City, Town,	or Location of	Octobe		2005 County of Death	5:12 PM
	LAdiiii	ici	Kline Hospice House			Mt. A				Frederi	lck
	Funeral Director		5. Social Security Number 176-03-1419 6. Sex 12 M 2	7. Age (In yrs. las F 91	t birthday). Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bi Min. March	23,	1914 9. Birth	plece (State or Foreign Yew York
	Maryland -f show live at	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Frederick	10c. City, 1 Fr	Town or Lo						10d. Inside City Limits
	Sa or 28e	Funeral Director	10e. Street and Number 7701 Dance Hall Roa	d		10f. Zip Code 2170	1			zen of What Cou	ntry?
920	be filed within 72 hours after death with the Maryland nat Hygiene. ad other than "natural", or items 23a or 28e-f show event, the Madical Examiner must be notified at	b	Ame:	Decedent Ever in U.S. of Forces? es 2 No , Give WW II or Dates:		Vas Decedent of I f Yes, specify Cub		n? (Specify Yes or No Puerto Rican, etc.)	Į.	4. Race - Americ Black, White, Specify: Whi	etc.
Maryland 21215-0036	d within 72 ho piene. r than "natur r e Madicel	Completed	15. Decedent's Education (Specify only highest grade complet Elementary/Secondary (0-12) Colleg	red) ge (1-4or 5+)	(Give	lent's Usual Occup kind of work done OO NOT use retire TESIGEN	during most o	of working		nd of Business/In	dustry
land;	d la b	To Be C	17. Father's Name (First, Middle, Last)  Dominic Antonio	Vona				s Name (First, Middle aria Gigli		Sumame)	
Man	12 sho h and l ris ma		19a. Informant's Name/Relationship (Type, Print)					or Rural Route Numb			
Baltimore, I	Pages 1 and 2 should nent of Health and Mer int: if item 27 is marke iry or other traumatic		Mrs. Susan F. Vona, wi  20a. Method of Disposition  **Burial 2 Cremation 3 Removal fr  **4 Donation 5 Other (Specify)	20b. Plac	e of Dispos	sition (Name of natory or other pla et Cemeter		d, Frederi . 31, 2005	20c. Loc	mb 2170] cation - City or To derick,	own, State
Baltii	permit. Pag Department Important; ii any injury o		21. Signature of Funeral Service Lipensee	M0025!	22. I	Name and Address Reeney at 106 Fast	oss of Facility and Bast	ford PA Fu St., Fre	neral	L Home	21701
88760,	cate be executed // Medical Examiner and prize transit the brial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Atheroso	nce of):	er the mode of dyl	ng, such as ca	ardiac or respiratory a	irrest,		Approximate Interval Between Onset and Death
.O. Box 68	death certifica e attending ph d for use as th	Physician/Medic	in the past 12 months?	outcome of pregnancy ve birth 2 ☐ Fetal de regnant at time of death nknown	ath 3	Ectopic pregnancy Other (specify)	/		23	3d. Date of delive	ery Day Year
S,	es tha	by	Part II. Other significant conditions contributing t	o death but not resulting	ng in the un	derlying cause giv	en in Part I.	23e. Did t			ne cause of death?
Record	The law ate has b page 2 si	Completed	Adominal Action	ic Anen	lysn	7		24a. Was auto perio 1 \( \text{Yes}		prior to cor death?	psy findings available inpletion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?			all post Oth	00	Death (Check only o	one)		H85Pir
of	ding h. After fune	ation: To	27. Manner of Death 28a. Da		Outpatient  Time of Injury	28c. Injur Wor	4   Nursi	ng Home 5 Resident		Other (Specify occurred	1) Hause
É	Mospitel or Attend 24 hours after death 5 Funeral Director: A etely filled in by the f	Certification:	3 Suicide 6 Could not be determined 28e. Pl	ace of Injury - At home uilding, etc. (Specify)	, farm, stre	et, factory, office		28f. Location (: City or Tox	Street and wn, State)	Number or Rura	l Route Number,
	To the Hospitel or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Medicai	29a. Certifier (Check only one)  Certifying Physician: To 2 Medical Examiner: On the and at 29b. Signature and title of certifier	the best of my knowled e basis of examination nanner stated.	dge, death and/or inv	occurred at the tirestigation, in my o	pinion, death	place, and due to the occurred at the time,	date and p	place, and due to	the cause(s)
}	F × F O		MAM	lane 1	4/	D <b>1</b> 6				signed (Month, l ober 27,	
0	N		30. Name and address of person who completed o			,	1 7:	. = -			
	Sta	te.		II, M.D., 2. Registrar's Signature		est Nint	n Stre	et, Freder	cick,	MD 217	/01
	Registr		NOV 0 2 2005	was At ,	COCA						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 11:35 AM Wolfe М /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Co. Glen Burnie Baltimore Washington Medical Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** October 24 1929 Maryland 1 M 2 □ F 76 218-26-0763 Director Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or iteme 23a or 28a-1 show any injury or other traumatic event, the Medical Examination with the medical examination. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Maryland Pasadena Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1992 Gooseneck Road 21122 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. I X Yes 2 No If Yes, Give 1948 Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 10th College (1-4or 5+) Foreman CSX railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John William Wolfe Sr. Mattie Elizabeth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Beverly Ann Wolfe 1992 Gooseneck Road Pasadena MD 21122 spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 11/6/2005 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stallings Funeral Home P.A. 21. Signature of Funeral Service License <u>3111 Mountain Road Pasadena Maryland 21122</u> 23a. Part f. Enter the disease, or com-shock, or heart failure. List only Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (of as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that interest and the cause) Examiner as the burial-transit certificate be executed ES that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical esn IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by page 2 should be Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 2 🗆 No Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 2 ER/Outpatient 3 DOA this After this funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 24 hours after death. • Funeral Director: A investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 40519 d 111105 Name and address of person who completed cause of death (Item 23a) (Type, Print) 11274 M. MUSARES : 1401 MADISON PARK, Glen Burnie, 21061 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State NOV 0 2 2005 Registrar

ames Wol-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item/2/a, periff, 6849, 11-2-05 TT

State of Maryland / Department of Health and Mental Hygiene Reg. No. U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 30 M 23 OCTOBER WARBLE 2005 JANICE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTMORE BAYriEN N/A MED CTR HOPKINS JOHNS 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2√□ F Yrs. Aug.15,1929 Virginia 76 213-26-0895 Director Usual Residence of Decedent death with the Maryland 10d Inside City Limits 10c. City. Town or Location 10b. County 10a. State ahow raf, or frams 23a or 28a-f abov Examiner must be notified at 1 TYPS 2 NO Directo Washington Hagerstown Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21742 United States 13733 Pennsylvania Ave. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 10 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: þ White 3 ☐ Widowed 4 ☑ Divorced "natural" Completed other than "natur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Western Electric Factory Worker 12 Years 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If tem 27 1s marked othe any injury or other traumatic avant, odge. 17. Father's Name (First, Middle, Last) Be Carrie Gibson James Morris 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1956 Ouentin Road Dundalk, Maryland 21222 John Warble (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gdns. 11/4/2005 Middle River, MD 4 Donation, 5 Dother (Specify Entembrent 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) AORTIC ANERYSM DAYS DISS ECTION WITH Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician a s the burial-t Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death the detached 9 Unknown 9 ☐ Unknown à signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown DISEASE ARTERY Completed been s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ◯ No CEREBROVASCULAR ACCIDENT 24a. Was an has 1 Yes 2 No 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death 2 Accident after death Diractor: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

DI MEDICAL DOCTOR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Do0 61901

WILLIAM HUND, MD. JOHNS HOPKINS BAYVIEW INBOICH CENER, 4940 EASTERN ALENUE BALTIMORE MOZIZZY

OCTOBER 31.

2005

-			1 - For State Registrar	State of I	Maryla			nt of H	ealth a		lental Hyg		005	354	41
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	Examir	ner	4a. Facility Name (If not institution, giv						Location of	Death			ounty of De		
12			Anne Arundel M  5. Social Security Number 6. S					napo.		A Urc	0.5			undel	
L	Funeral Director		218-14-3607	1X M 2□ F		83 Yrs.	Months		Hours	Min.	8. Date of Birth (Month, Day, Dec 13	Year) 192	21 Ma	rthplace (State or Country) ryland	Foreign
	land		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	ocation							10d. Inside City	/ Limits
	Mary I-f eh	ţō	Maryland Anne A	rundel	]	Lothia	ın							1 □ Yes	
	r 28a	lrec	10e. Street and Number				10f. Zip	Code		<u> </u>	1	0g. Citize	n of What C	ountry?	
	th wit	by Funeral Directo	5119 Moreland	Lane				207	11			US	SA		
	eme erra	Iner	11. Marital Status	12. Was Decede Armed Force		J.S. 13.	Was Dece	dent of Hi	spanic Orig	in? (Spe	ecify Yes or No- Rican, etc.)	14		encan Indian,	
36	s afte	Y.	1 Never Married 2 Married	1 XYes 2 [	□No		1 ☐ Yes		Specify:	, doito	noun, etc.,		Black, Wh pec <i>ify:</i> $B1$		
8	be filed within 72 hours after death with the Maryland hat Hygiene. Ad other than "natural", or feme 23a or 28a-f ehow event, the Modical Examinat must be notified at	a pe	3√Widowed 4 □ Divorced  15. Decedent's Ed	Year or Date	s: 1943	3-44									
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þ	be filed tat Hygid d other event,	BeC	17. Father's Name (First, Middle, Last)						18. Mother	's Name	(First, Middle, A				
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Maryland 21215-0036	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (								l Route Number,	City or T	own, State,	Zip Code)	
	s 1 and f Health Item 27 other tr		Robert Wallace	(Son)					's Wa	41.				d. 2063	39
Baltimore,	0 0		20a. Method of Disposition  1 X Burial 2 Cremation 3	Removal from Sta	e Che	Place of Dispo	isition (Nar	ne of	ans	D	ate	20c. Loca	tion - City o	Town, State	
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Bal	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licen	see 11004	83	₩ 8	m. R	d Address eest est	sof Eacility St.	ons Ann	Mortu apolis	ary,	P.A	401	
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Ž.	Physician		Immediate Cause (Final disease or condition	. Ful	ma	ant-	hep.	atre	tas	lur	2			Onset and De	eath
	/Medical Examiner		resulting in death)	Due to (or a	is a consec	quence of):	/							and	
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9	g phy as the			, u.											
Вох	attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			3r-4:-					230	I. Date of de	livery	
B.	deat	sicie	in the past 12 months? 1 Yes 2 No	4 Pregnant			JEctopic pr ] Other <i>(sp</i>						Month	Day Ye	ar
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	To the within To the comple	Me	29b. Signature and title of certifier	4			29c	. License	number		29			h, Day, Year)	
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ore,	es 1 a of Head fitem		20a. Method of Disposition 1 Burial 2 Cremation 3		20b. Pla	ce of Dispos	sition (Name of place)		Date	20c. Lo	ocation - City or	
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Ä	Physicien: The law r this certificate has t iral director, page 2 s	Com	- ANEM	-					— autor perfo 1  Yes	osy irmed? 2 A No	prior to death? 1 ☐ Yes	completion of cause of
Vita	icien: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Out		Death (Check only o	ne)		
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ľ	) [	ij	30. Name and address of person who るしかんた。	pleted cause of de	ath (Item 2	23a) (Type, P	Print) 13	ON	SECOURS	K	DSFITA	9-2-
370	* Sta	te	31. Date filed (Month, Day, Year)	2. Registrar	r's Signatu	18 Anass	13 W. 13	7-210	3/ 1	54-2	10 17	27 2005 9 L. 1 D. 21213
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			1 - For State Registrar	Olato of	many tan				Death		-	Reg. No		5	35443
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Û	Funeral Director		5. Social Security Number 213 – 14 – 4136	5. Sex 1 □ M 2√√√F	r. Age (In yrs. 88	iast birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da	ıy, Year)	1 77		olace (State or Foreign ntry)
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ă	death e atte d for	Iclai	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregna	th 2 ☐ Feta int at time of d		Ectopic p Other (s)						Month		Day Year
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	a E a	by F	Part II. Other significant condition	s contributing to dea	ath but not res	sulting in the u	nderlying	cause give	en in Part I.						he cause of death?
Vital Records,	w require been sign should t	Completed			-						10	Yes 2	□ No 31	☐ Prob	pably 4 Unknown
Sec	has b	nple					-				24a. Was autor		prio	r to co	ipsy findings available inpletion of cause of
ᄪ												2 No	1 [	th? Yes	2 🗆 No
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of	g Phy er this	n: To	27. Manner of Death	28a. Date o	f Injury	28b. Time o		28c. Injury	at		ne 5 🗆 Resi				V)
ion	ath. rr: Aft	atlo	1		i, Day Year)	Injury	М	Work 1 □ \	r? Yes 2 □ ì	No					
Division of	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 286. Place	of Injury - At h	ome, farm, sti	reet, factor	y, office		2	28f. Location (	Street an wn. State	d Number	or Rura	al Route Number,
	Hospital or 24 hours afte Funerai Dir tely filled in I			- 1							· · · · · · · · · · · · · · · · · · ·				
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the teminer: On the ba	sis of examina	owledge, deat ation and/or in	h occurred vestigation	at the time n, in my op	ne, date and pinion, deat	d place, a th occurre	and due to the ed at the time,	cause(s) date and	and mann place, and	erass due to	tated. the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	And main	or stated.		29	c. License	number			29d Da	te signed (/	Month,	Day, Year)
	- s - ō		Melyman	YD.	211		-	D5	toa	0	1				
1	1		30. Name and address of person w	ho completed cause	of death (Ite	p_23a) (Type,	Print)			A	.,	100	UMN	10	1,2005
4	8.		2401 Brande	rmill B	IVD. E	sute	3	30,	Ga	neb	vills, 1	40	210	5-	+
100	Sta		31. Date filed (Month, Day, Year)	2 2005 N	distrer's Sign	ature	A	Nº E			,				
15	Registr	वा	NOVO	M FARA	HARLAND.	JA P		San San San San San San San San San San							

State of Maryland / Department of Health and Mental Hygien 35444 For State Registrar Certificate of Death Rea. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 2005 October 3Ó 1:25 P. Frank Charles Wisniewski /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Catonsville 1513 Park Grove Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1XM 2□F 188-07-5926 301910 Pennsylvania 95 October Director Usual Residence of Decedent 10c City Town or Location 10d. Inside City Limits 10a. State 10b County Hygiene. other than "natural", or items 23a or 28a-f show rent, the Modical Examinar count be notified at 1 ☐ Yes 2 XNo Directo Maryland Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1513 Park Grove Avenue 21228 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Stee1 5 Machinist 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked ofth sny lighty or other traumatic event, 2008. 17. Father's Name (First, Middle, Last) Josephine Stefanoski Alexander Wisniewski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1513 Park Grove Avenue, Catonsville, MD 21228 Stanley Wrisk/Son 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
St. Mary's Catholic
Cemetery 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 2005 Wilkes-Barre Nov. 5, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Sterling Ashton Schwab Funeral Home, 2175
736 Edmondson Avenue, Baltimore, MD, 21228 21. Signature of Foreral Service License Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) signed by the el 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably **Onknown** Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy performs page 2 s certificete 1 ☐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only or (No Other: 4 Nursing Home 2 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) this iers! Director: After th 27. Manner of De 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours e To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, 29b. Signature and title of certifie 30, Name-and addre ited cause of death (Item 23a) (Type, Print) 00 31. Date filed (Month, Day, Year) 32. Rec State NOV 0 2 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death Day OCT **Physician** 2005 NANCY THEOBALD WEHR 30 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** BLAKEHURST HEALTH CENTER TOWSON BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 0 1 / 1 9 / 1 9 0 4 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex 9. Birthplace (State or Foreign Months 1 M 2 F Yrs. 214-46-8513 Director 101 MARYLAND Usual Residence of Decedent deeth with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28e-f show 7 le marked other then "neturel", or items 23a or 28e-f shov treumatic event, the Madical Examinar must be notified at **Funeral Director** MD BALTIMORE TOWSON 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1055 WEST JOPPA RD 21204 USA permit. Pages 1 and 2 should be filed within 72 hours after deen Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "neturel" .... any injury or other treumatic event 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12YRS College (1-4or 5+) OPERA SINGER OPERA SINGER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRANCIS deWOLF THEOBALD EDNA DULANY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EMILY EMERICK (G-DAUGHTER) 2852 POCOCK RD MONKTON, MD. 21111. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DRUID RIDGE 11/3/2005 PIKESVILLE, MD. 22. Name and Address of Facility NS<sub>N</sub>&TSONS<sub>D</sub>C 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Year 7 Physician un gestive disease or condition resulting in death) /Medical Due to (or is a consequence of): Examiner Sequentially list conditions, if any, Lading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 - No To the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 Tes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Thursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manne Death 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending death, 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours. 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 532783 30. Name a d o dress of person who completed cause of death (Item 23a) (Type, Print) JOSEPH ADAMS M.D. 6701 N. CHARLES ST TOWSON, MD. 31. Date filed (Month, Day, Year) M. Registrar's Signature Registrar NOV 0 2 2005

			For	State of Marylan	•			Mental Hyg	giene	
			State Registrar		Cer	tificate of l	Death		10g. NO 115	25116
to-	Physici		1. Decedent's Name (First, Middle, Last)	shite				2. Date of Dea	Day Year	1625 PM
100	/Medic Examin		4a. Facility Name (If pot institution, give s	treet and number) - Hospita	1.	4b. Gity, Town, or	Location of Death		4c County of De	more
	Funeral Director		5. Social Security Number 6. Sex 578-52-1214	7. Age (In yrs.)	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey March 6	r, Yeer) C	rthplece (Stete or Foreign country)
	pu ,		Usual Residence of Decedent  10a, State 10b, County	10c Cit	, Town or Lo	ation				10d. Inside City Limits
	Maryla I-f shov	tor	Md Baltimore		ndallst					1 Yes 2 No
	with the a or 28a be roll	Funeral Director	10e. Street and Number 3610 Dovedale Road			10f. Zip Code 21133	l.		10g. Citizen of What C	ountry?
	ms 23	era		12. Was Decedent Ever in U.	S. 13. V	Vas Decedent of H	ispanic Origin? (S	pecify Yes or No-	14. Race - Am	
36	be filed within 72 hours after death with the Maryland hat Hygiene. Id other than "natural", or liems 23s or 28s-f show event, I'm Medical Exam for must be rediffed at	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 Yes 2 No WWI: If Yes, Give WWI: Year or Dates:	<u>Γ</u> 1	Yes, specify Cuba	Specify:	o Hican, etc.)	Specify: Wh	
9	72 hou natura		15. Decedent's Educ	cation	16a. Deced	ent's Usual Occup	ation	4.7	16b. Kind of Busines	s/Industry
215	within 7 ene. than "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done of OO NOT use retired	1)		Westinghou	se Corp.
22	e filed within at Hygiene. I other than vent, the me		17. Father's Name (First, Middle, Last)	Ĺ;	erecti	rical eng		ne (First Middle	Maiden Sumame)	
Maryland 21215-0036	2 should be f and Mental H is marked ot sumstic ever	To Be	John White					V. Bair		
	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (Ty) Donna A. White (spe						r, City or Town, State, rn, Md 2113	
ore,	of Hez fitem r othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	20b. P	lace of Disposemetery, crem	sition (Name of natory or other place	ce)	Date	20c. Location - City o	
Baltimore,	trent of tant: If it itury or o		*4 □ Donation 5 □ Other (Specify)	Lak	-	Memoria		05	Sykesville	
Bai	permit. Pages 1 an Depertment of Heal Important: If item 2 eny injury or other spece.		21. Signature of Funeral Service License  august Haught 3		P.	O. Box 1	ss of Facility Ha .95 Sykes	ight Fun ville, M	eral Home& ld 21784	Chape1
8760, 村	Cate be executed hysicien and hysicien and hysicien and the burial-transit the burial-transit the burial-transit than the buri	dical Examiner	23a. Part1. Enter the disease, or complishock, or heert failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	uence of):	ertic (	Λ	/uscil (c	2 1	Interval Between Onset and Death
P.O. Box 68	ne death certific the attending p hed for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1  Live birth 2 Feta 4 Pregnant at time of d	Ideath 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	elivery Day Year
	signed by d be detac	by	Part II. Other significant conditions con	tributing to death but not res	ulting in the un	iderlying cause give	en in Part I.	1	obacco use contribute res 2 □ No 3 □ F	to the cause of death?
al Records,	The law ate has b page 2 sl	Completed						24a. Was a autop perfor 1 Yes	sy prior to death?	utopsy findings available completion of cause of
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		oth		th (Check only or	ne)	
o	Phys r this ral di	1: To	1 Yes 2 No	28a. Date of Injury	28b. Time of	28c. Injun	v at		ence 6 Other (Sp. ow injury occurred	ecify)
ion	Attending r death. ector: After by the fune	atlor	1 ■ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	Injury	Worl	k? Yes 2⊡No			
Division	F F F	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	eet, factory, office		28f. Location (S City or Tow	itreet and Number or F m, State)	Rural Route Number,
	Hospitel	edical C		ician: To the best of my kno ner: On the basis of examina and manner stated.						
	To the within 2 To the comple	Med	29b. Signature and title of certifier			29c. Licensi	e number	- 2	29d Date signed (Mor	ith, Day, Year)
	->-0		> ( Starri	andi		201	5626	6 (	Schober	30, 2005
	10	. (	30. Name and address of person who co	mpleted cause of death (Item	A 1		1 170	dolla	m, MD 21	122
	Sta	to	31. Date filed (Month, Day, Year)	38. Registrar's Signa	oc Or	a.Ctik	a pear	T GULLION	011/19/ 61	33
	Registr		NOV 0 2 2005	Fred to the	Koo	de la				

			Plea	ase Type or Pri State of M									_		
			1 - For State Registrar	State of W	iaiylailu /				Death	J IVIC	illaiiiy	Reg. No.		354	47
			Decedent's Name (First, Midd)							2	Date of D			3. Time o	of Death
	Physici /Medic				ira Wa	atkin				C	)ct	21	200	5 091	7 M
	Examin	er	4a. Facility Name (If not institution  5. Social Security Number	l of Bal	ge (In yrs. last	hirth chu)	4b. City, Bu	Itu	Location of De	a	Date of B			N/A inthplace (State	or Foreign
LE .	Funeral Director		218-13-4361 Usual Residence of Decedent	1 M 2X F	32	Yrs.	Months	Days		lin.	(Month, D Jul 19	9, 1973	3.00	Maryland	a, , a, a, g,
	Maryland -f ehow	tor	10a. State 10b. County  Maryland	N/A	10c. City, To	own or Lo	cation	Ва	altimore					10d. Inside 0	ity Limits
	s with the	I Director	10e. Street and Number 2937 Garnson Bould	evard - Apt T			10f. Zip	Code	21216			10g. Citia	zen of What C	S.A.	
020	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mealth Hygiene. I Health and Mealth Hygiene. I fem 27 ie marked other then "neturel," or items 23a or 28e-f ehow other traumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status  1 X Never Married 2 Mar 3 Widowed 4 Divorced	If Yes Give	? I No	'	Vas Deced Yes, spec	cify Cuba	ispanic Origin? In, Mexican, Pu Specify:	(Specification Rice	y Yes or N an, etc.)		14. Race - An Black, Wh Specify:	nerican Indian, ite, etc. Black	
0-61717	filed within 72 ho Hygiene. other then "netur. ent, the Medical i	Completed		nt's Education est grade completed)  College (1-4or		6a. Deced (Give life.	lent's Usua kind of wo DO NOT us	rk done e se retired	ation during most of the during most of the demaker	working		16b. Kir	of Busines	s/Industry Home	
מומומי	should be filed nd Mental Hyg marked othe imatic event,	To Be C	17. Father's Name (First, Middle, Ant	, Last) hony Brooks					18. Mother's N	Name (F			Sumame) <b>Natkins</b>		
Mary	1 and 2 shou Health and M tem 27 ie mar other traumat		19a. Informant's Name/Relations  Jeannette Watkins		1				and Number or Avenue B					Zip Code)	
allillore	permit. Pages 1 an Department of Heal Important: if Item 2 any injury or other once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (5)		20b. Place ceme	itery, crer	sition (Name natory or o us Mem	ther plac		Date 10	/31/05	7.0		r Town, State , Maryland	
Dair	Departi Departi Importa any Inju		21. Signature of Funeral Service	Licensee	3/01	22	Fs	step B	ss of Facility rothers Fu utaw Place	neral Baltir	Service nore, M	P. A. d 2121	7		
	Physician /Medical Examiner		23a. Part1. Enter the disease, o shock, or heart failure. Lis tmmediate Cause (Final disease or condition resulting in death)	a. Comple		\S (	<b>^</b>		UOMY	opu	Hhy	arrest,		Approxima Interval Be Onset and	tween
,00700	w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<b>1</b>	s a consequences										
. DOX 0	The law requires that the death certificate be site has been signed by the attending physicie page 2 should be detached for use es the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No		e of pregnancy 2  Fetal dea at time of death		Ectopic pr Other (sp		,			2	3d. Date of d	elivery Day	Year
cords, r.	uires that I	by	Part II. Other significant conditions of the con	A	but not resultin	g in the u	nderlying c	ause grv	en in Part I.				se contribute	to the cause of	death?
משבו וג	:The law rec cate has been ;page 2 shou	Completed	k grat EM	t pulmara	rye	mb	oli's	<u></u>		-	24a. Wa: auto perf 1  Yes		24b. Were a prior to death?		available cause of
<u> </u>	sician certif recto	o Be	25. Was case referred to medical examiner?	Hospital:	ing ME	Outpatier	t 3 DC	Oth	er:				G □Other (Sp	ocifu)	
5	ding Phy th. : After this s funeral d	-	27. Manner of Death  Datural 5 ☐ Pendi	28a. Date of In	iury 28t	D. Time of Injury		28c. Injun Wor			1. Describe			outy	
	at or Atter s after dea il Director od in by the	Certification:	3 Suicide 6 Could determ	mined 286. Place of Ir	njury - At home, atc. (Specify)	, farm, str	eet, factory	y, office		281	Location City or To	(Street and iwn, State)	d Number or I	Ru <i>ral Route N</i> ur	n <i>ber</i> ,
	To the Hospital or Attending Physician: The law within 24 butus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	edical	29a. Certifier (Check only one)	ing Physician: To the bes I Examiner: On the basis and manner s	of examination	dge, death and/or in	occurred restigation	at the tin	ne, date and pla pinion, death o	ace, and ccurred	due to the at the time	cause(s) , date and	and manner a place, and de	as stated. ue to the cause(	s)
	To t To t	×	29b. Signature and title of certific	er	^	15	290	c. Licens	e number	a –	,	29d. Date	e signed (Mo	nth, Day, Year)	
	1		30. Name and address of person	a who completed enuce of	death /Item 22	a) (Tunn	Brint,	אכנ.	2165	1		UC	7-62	, 200	15
L	K'		Ma HALL	D. Smit	)	1	ar of	Hos	pital	0	+ Bo	Uti	mire		
34 36	Sta Registr		31. Date filed (Month, Day, Year NGV 0	2 2005 32 Regis	trar's Signalure		30860								

			State of Maryla 1- State Amend Item 19b per fh G849	nd / Depa 9 11-2-	artment of Health and l 05 tas dificate of Death	Mental Hygie, Reg.	2°005	35448
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  BERNICE  D.	WE:	INER		Day 2005	3. Time of Death 9:58 PM
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Deat		4c. County of Dear	th
			Sinai Hospital of Battimo  5. Social Security Number 6. Sex 7. Age (In yrs		Baltimore If Under 1 Year   If Under 24 Hrs	Q Date of Birth	0.8	N/A
	Funeral Director		216-24-7545  Usual Residence of Decedent	s. last birthday) 7 Yrs.	Months Days Hours Min.	MAY 5, 19	28	thplace (State or Foreign puntry) MD
	yland sow			City, Town or Lo	ocation			10d. Inside City Limits
	e Mar	ctor	MD BALTIMORE	OWING	GS MILLS			1 ☐ Yes 2 🏋 No
	with th	Director	10e. Street and Number		10f. Zip Code 21117	10g.	Citizen of What Co	ountry?
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23e or 28e-f show this the Medical Evarinat must be recilified at	Funerai	4730 ATRIUM COURT #369  11. Marital Status 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	U.S. 13.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puen	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	erican Indian,
920	urs aft	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No Specify:		Specify:	WHITE
5-003	72 hours	eted	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of wor	rkina 16b	. Kind of Business/	/Industry
121	e filed within 72 ho al Hygiene. I other than "natur vent, I're Medical	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	SALES	DO NOT use retired)		TAIL	
מ	illed Hygi other	ВеС	17. Father's Name (First, Middle, Last)	ONEE		ne (First, Middle, Maid		
<u>la</u>	D = D 0	To B	DAVID	DOGOLO	OFF ROSE			HOFF
Maryland 21	2 2 2		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number of Ru			
	1 an Heall em 2 ther	1 8		Place of Dispo	MISTY TOP PATH -		. Location - City or	
Baltimore,	permit. Pages Department of I Importent: If it any injury or o			TH TFIL	LOH CEMETERY 11/0		WOODLAWN	
Ba	Depar Impor any ir		21. Signature Funeral Service Licensee		Name and Address of Facility SO REISTERSTOWN			
ī			23a. Part1. Enter the disease, or complications that caused the deashock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death
Ü	Physician /Medical		resulting in death)		Heart Disease	2		10 years
ı	Examiner		Due to (or as a conse	quence of):				
	led sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	quence of):				
,	ificate be executed g physician and as the burial-transit	Examin	that initiated events resulting in death) Last c. Due to (or as a conse	quence of):				
98/60	ate be nysicia he bur	edicai	d					
		Med	IF FEMALE:				1	
). Box	w requires that the death certif been signed by the attending should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No 9 Unknown	tal death 3	Ectopic pregnancy Other (specify)		23d. Date of del	ivery Day Year
J Ö	hat the		9 ☐ Unknown  Part II. Other significant conditions contributing to death but not re	sculting in the u	adarhijaa aayaa ayaa in Rad I	23a Did tobacc	o use contribute to	the cause of death?
Vital Records,	requires that the een signed by th hould be detache	ompleted by	Diabetes Mellitus, Conges	-		1 Tes		obably 4 Unknown
eco	G O CI	piet	. ,			24a. Was an autopsy	24b. Were au	topsy findings available
<u> </u>	The ate	Con				performed	? death?	
	Physicien: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐	7500	Othor	th (Check only one)	. Flori (a	
וסו	ding Phys h. Atter this funeral di	H	27. Manner of Death 28a. Date of Injury	28b. Time of	t 3 DOA Street: 4 Nursing H	ome 5 Residence 28d. Describe how in		ory)
SIO	endin eath. or: At	atio	2 Accident investigation	Injury	M 1 Yes 2 No			
Division	spitel or Atten ours after deat serel Director: filled in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At i building, etc. (Special Countries)	nome, farm, stre ify)	eet, factory, office	28f. Location (Street City or Town, Sta	and Number or Ru ate)	iral Route Number,
	To the Hospitet or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edicai (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my kn (2 Medical Examiner: On the basis of examinand manner stated.	owledge, death	n occurred at the time, date and place restigation, in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as and place, and due	stated, to the cause(s)
	To the within 2	Mec	29b. Signature and title of certifier	~	29c. License number	29d. [	Date signed (Month	h, Day, Year)
1			· Eller Jufman &	90	RES-000	00	tober	29,2005
			30. Name and address of person who completed cause of death (Ite Eileen Zingman, po	m 23a) (Type, I	Hospital of	Baltimo	re	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 2 2005 32. Registrar's Sign	ature				

			1 - For State Registrar	State of Maryla	nd / Depa	artment of tificate of	Health and I Death		giene Rag. No.	005	35449
	Physici	20	Decedent's Name (First, Middle, L.)	ast)				2. Date of De	ath Day	Year	3. Time of Death
	/Media		Julia	М.		Yo	oung	10	25		
2	Examir	er	4a. Facility Name (If not institution, g	ive street and number)			or Location of Death	1	4c.	County of Dea	ath
			1716 Moreland			Baltin					
п	Funeral			Sex 7. Age (In yrs	. last birthday)	If Under 1 Year Months Days		8. Date of Bir (Month, Da	th ly, Year)	9. Bi	rthplace (State or Foreign country)
	Director		219-22-5728 Usual Residence of Decedent	86	Yrs.			05 0		L9	VA
	land ow		10a. State 10b. County	10c. C	ity, Town or Lo	cation					10d. Inside City Limits
	Mary	ō	MD NA		Baltim						1∑Yes 2 No
	28a	Je.	10e. Street and Number			10f. Zip Code			10a. Citi	zen of What C	country?
	3a o		1716 Moreland	Ave			21216		3	U.S.A	•
	within 72 hours after death with the Maryland ene. Itan "natural", or Items 23e or 28e-f ehow the Madicel Exemiter maist be molified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in I	U.S. 13. \	_	Hispanic Origin? (Saban, Mexican, Puert	pecify Yes or No	)-	14. Race - Am	
9	or Ite	Ξ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	1			o Rican, etc.)		Black, Whi	ite, etc.
9	ral',	i by	3 Widowed 4 ☐ Divorced	Year or Dates:		To Yes 2⊡XNo	Specify:			Specify:	Black
2	72 h	Completed	15. Decedent's I (Specify only highest g		(Give	ient's Usual Occu	during most of work	kina	16b. Ki	nd of Business	s/Industry
2	Man vithin	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retire	ed)	•	L .		
2	be filed within 72 hours after death with the Marylan tal thygiene.  I al thygiene.  I al thygiene.  I all the Madical Exaction and be notified at event.		12th grade  17. Father's Name (First, Middle, Las	na	Cr	ossing					y/Schools
בב		Be		,			18. Mother's Nam			Sumame)	
چ	should be filed vind Mental Hygie marked other tumatic event, in	7	James S. Marti				Lillia				
Maryland 21215-0036	~ ~ 4		19a. Informant's Name/Relationship		165,657		t and Number or Ru				
	is 1 and 3 of Health Item 27 other tri		John W. Young - 1  20a. Method of Disposition		Place of Dispo	River sition (Name of	Green Dr	Date Atl			
وّ	Pages nent of t int: If Ite		1 ☐ Burial 2 ☐ Cremation 3	Removal from State	cemetery, cren	natory or other pla	ace)			cation - City or	
Baltimore,	it. Partimer rtant rtant		4 Donation 5 Other (Spec		Woodla			1/05	Balt	imore	Co, Md
E R R	permit. Pages Department of Important: If It any injury or o		21. Sonature of Funeral Service Lin	John	43		ash Ave,			, Md	21215
			23a. Fart1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the dea y one cause on each line.	th. Do not ente	er the mode of dy	ing, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition	Myoca	SDIM	INF	PREMO	9			Onset and Death
,	/Medical		resulting in death)	Due to (or as a conse	quence of):						1
	Examiner		Sequentially list conditions	b. ATTIERO	SCULO	The cover	COTTO DITUD	コレビファ	1152	132	42725
_	Q #	ne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse						1	
	and and trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conse	37510	<i>⊳</i>					7275
8/60,	Se ex		rosawing in additity case								1. A. A.
Σ 20	icate be executed physicien and s the burial-transit	dicai		d. 149 24	15 17 VV	1/+					4542)
٥ ×	death certificate be executed e attending physicien and id for use as the burial-transit	Me	IF FEMALE:	00-14				7.50	1		
ROX	ath c	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1☐Live birth 2☐Fet	al death 3	Ectopic pregnand	;y		2	3d. Date of de Month	livery Day Year
		ysic	1 ☐ Yes 2 D No 9 ☐ Unknown	4☐Pregnant at time of of the street of the	death 5□	Other (specify) _				William	Day Toal
7.	that the de led by the a detached t	P.	Part II. Other significant conditions	contributing to death but not re-	sulting in the un	dochring source of	van in Port I	22a Did to	aba asa u		o the cause of death?
cords,	9 5 9	by		oormooting to double but not re-	saking in the di	denying cause gi	veri ili Fait i.		res 2	r	robably 4 Unknown
Ö	w requir s been si should	ete							103 21	VIO 3[]11	
ď)	has ye 2	Completed						24a. Was autop	sy	24b. Were at prior to	utopsy findings available completion of cause of
	ician: The certificate hi rector, page								rmed? 20 No	death? 1 ☐ Yes	2 □ No
Vita	Physician: rthis certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		I OH	26. Place of Deat		-		
ō	Phys this ral di	2	1 Yes 2 No  27. Manner of Death	1 ☐ Inpatient 2 ☐	28b. Time of	3 □ DOA	her: 4 Nursing Ho				icity)
5	ding f	틸	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	28c. Inju Wa	rk? ]Yes 2∐No	28d. Describe h	iow injury	occurred	
DIVISION	Attending ir death. ector: Atter by the fune	lica	3 ☐ Suicide 6 ☐ Could not	DB Disco of lains. At h	nome farm stre		1.62 5 1.40	28f Location /9	Strant and	Alumbar or Pr	ural Route Number.
	al or Attend after death Director: / d in by the f	Certification:	4 Homicide determined	building, etc. (Speci	ify)	et, lactory, office		City or Tow	vn, State)	I WUITIDET OF A	urai Houte Number,
- 1	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	C	29a. Certifying P	hysicien: To the best of my kn	Owledne death	occurred at the fi	me date and place	and due to the	201100(-)	and many	atatad
	24 h	edicai	(Check only 2 Medical Exa	miner: On the basis of examination and manner stated.	ation and/or inv	estigation, in my	opinion, death occur	red at the time,	date and	place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licen:	se number		29d. Date	signed (Mont	h, Day, Year)
	350	1	1/2	) (/e m		D3	6031		1	1/2.0	20 5
. 1	12		30. Nell e and address of person who	completed cause of death (Ital	m 23a) (Tuna 1				- / (	0 ,24	()
4	6		DONNAL PR	LZP M UI	G 110 . C	SNIOTA	MET S	ות כו		20-	m 21201
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	asunc	001 100	11166		SITUL	1110 21201
	Registra	-	NOV 0 2 2005	Bear St.	A POST						

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieris O. O. C.

			1 - For State Registrar	State of Maryla		rtificate of			Reg. No.	5	35450
	Physicia		1. Decedent's Name (First, Middle, Las	t)				Date of Dea     Month		Year	3. Time of Death
	/Medic			ston				Month 10	29 <sup>Day</sup>	05°	21:38P M
	Examin	er	4a. Facility Name (If not institution, give Suburban Hospit			4b. City, Town, o Bethes	r Location of Death ada		4c. County	of Death	ry
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs	. last birthday)	ff Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	h ( Year)	9. Birthp	lace (State or Foreign try) Carolina
	Director		241-52-5435 Usuaf Residence of Decedent	3 × 2 □ F   7	O Yrs.	Monins Days	Hours Wiri.	11 02	2 34	Norti	"Carolina
	/land		10a. State 10b. County		ity, Town or Lo					1	0d. Inside City Limits
	a-f sh	ctor	D.C.	W	lashing	ton					1 ☑ Yes 2 ☐ No
	or 28	Oire	10e. Street and Number			10f. Zip Code			10g. Citizen of		itry?
	ath w	Funeral Director	121 Darrington S				032		US		
	er de Item	une	11. Marital Status  1 ☐ Never Married 2 【X Married	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ☐ XNo	J.S.   13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Had	ce - Americ ck, White,	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mennia Hygiene.  In marked other than "naturel", or items 23s or 28s-f show aumatic event, the Madical Examinar must be notified at	by	3 Widowed 4 Divorced	ff Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:		Specif	Bla	ck
Š	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece	dent's Usual Occup	ation	ina	16b. Kind of B	usiness/Ind	dustry
2	within ne.	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of work	9	17a - h d		Coo Co
2	Hygie Hygie ther t		11th.  17. Father's Name (First, Middle, Last)	·	COIII	pressor C	18. Mother's Name	(First Middle			Gas Co.
au	d tal	To Be	Paul Alston				Addie J			,	
ary	should and Men marke umatic	-	19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Street	and Number or Rura	al Route Numbe	r, City or Town	State, Zip	Code)
	s 1 and 2 should if Health and Men itam 27 ie marke other traumatic		Ollie Alston/Wif	e	121 1	Darringto	n St. S.W	. Washi	ngton,	D.C.	20032
ore	of He of He if itam r oth		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □	20b.	Place of Dispo cemetery, crea	osition (Name of matory or other plac	(9:	Date	20c. Location	- City or To	wn, State
Ĕ	Pages tment of I tant: If its jury or o		4 ☐ Donation 5 ☐ Other (Specify	)		ill Cem.	11-7-		Suitla		
Baltimore,	permit. Pages Department of Important: If it any injury or conce.		21. Signature of Funeral Service Licen	skall			ss of Facility MAr				
T Save	\$ <b>4</b> .30		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only				St. N.W.			7.0. 2	Approximate
	Physician		Immediate Cause (Final		7						Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	a. Due to (or as a conse	quence of).	217					
	Examiner		Sequentially list conditions	b	Dec	5170	201	cen			
	sit ad	iner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dee to (or as a conse	quaries of):	55.00	0.04		í		
	and al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conse	guence of):	CIAC	. A V.	2 res	14	_	
68760,	tificate be executed g physicien and as the burial-transit			b. Use to (or as a consect.  Due to (or as a consect.)	14-	1 2 He	im				
89	tificati g phy as the	ledical		u							
ŏ	leath certifics attending ph	an/N	230. Was decedent pregnant	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnancy				te of delive	
Ö.	The law requires that the death cer tte has been signed by the attendir bage 2 should be detached for use	Physician/N	in the past 12 months? 1 □ Yes 2:□ Yo 9 □ Unknown	4☐Pregnant at time of 9☐Unknown		Other (specify)			Mo	onth	Day Year
P.0	that the ed by detacl	Ph)	Part II. Other significant conditions co	antributing to death but not re	sulting in the u	nderlying cause gry	en in Part I	23e. Did to	bacco use con	tribute to th	e cause of death?
Records,	w requires that the de been signed by the is should be detached	d by	•			moonymy sacco gre	on arrait.				ably 4.⊠Unknown
Ö	w req	iete						24a. Was a	an 24b.	Were auto	psv findings available
E E	: The law cate has I page 2 s	Completed						autop: perfor	med?	prior to cor death? 1 \( \text{Yes} \)	psy findings available impletion of cause of
		BeC	25. Was case referred to medical				26. Place of Death	1 ☐ Yes Check only or		1 1 1 1 1 1 1 1 1	2 140
	Physic this ce at direc	2	TO THE ZEE ING	Hospital: 1 ☐ Inpatient 2 ☐	EP Outpatier	nt 3□ DOA Oth	er: 4 Nursing Ho	me 5 Resid	ence 6 Oth	ner (Specif)	1)
Division of	After	ion:	27. Manne d Death 1  atural 5  Pending	28a. Date of Injury (Month, Day Year)	28b. Time o fnjury	Wor		28d. Describe h	ow injury occur	red	
Sic	f or Attend after death Director: /	icat	2 Accident investigation 3 Suicide 6 Could not be		nome form et		Yes 2 □No	28f Location (S	treat and Numi	her or Rum	l Route Number,
ā	a # F	Certification:	4 Homicide determined	building, etc. (Spec	ify)	eet, factory, office		City or Tow	n, State)	or or riora	THOUSE NUMBER,
	Hospital 24 hours a Funeral ( tely filled	edicai C	(Check only 2   Medical Exam	ysician: To the best of my kn iner: On the basis of examin	owledge, deat	h occurred at the tir	ne, date and place,	and due to the c	cause(s) and made	anner as st	ated.
	the the	Med	one)  29b. Signature and title of certifier	and manner stated.		29c. Licens			29d. Date signe		
1	F 2 3		Mullian	B. Cin	enn						
1	シュ!		30. Name and address of person who o	$\mathcal{T}$		Print	3718 D.O	860	001	D	DN
-	Sta	to	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	5/2		600	PSET	CUN	1- 1
100	Registr		NOV 0 3	2005 Maria	a wall	Contract of the second			-		

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20/62/01

Alston, Sames

State of Maryland / Department of Health and Mental Hygiene | 35451 1 - For State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician 2:05 A M 2005 OCT 26 GRACE ELIZABETH ABBOTT /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY NATIONAL NAVAL MEDICAL CENTER BETHESDA If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year 10-25-2005 Birthplace (State or Foreign Country)
 Maryland 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1 □ M 2 🖔 F Hours 0 Unobtainable Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County ir than "natural", or Itama 23a or 28a-f show the Medicul Examiner must be notified at 1 X Yes 2 No Severn Anne Arundel Director Maryland 10f. Zip Code 21144 10g. Citizen of What Country? 10e. Street and Number 1818 Chatfield Terrace United States America Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 18 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Never Worked Never Worked othar 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy.
Important: If Item 27 Is marked othal any injury or othar trainments. 17. Father's Name (First, Middle, Last) Be Amanda V. King Richard Abbott ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1818 Chatfield Terrace Severn, Maryland 21144 Richard Abbott/Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 Oremation 3 □ Removal from State Nov. 3, 2005 Alexandria, VA Mount Comfort 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleck Funeral Home 7601 Sandy Spring Road Laurel Maryland 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician HOLOPROSENCEPHALY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de: 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, by 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 24 No 1 Yes Division of Vital Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Tyes 2**X** No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death After t Certification: Hospital or Attanding 5 Pending investigation 1 🕅 Naturai 1 ☐ Yes 2 ☐ No after death. М 2 Accident the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide filled in within 24 hours a To the Funaral C \*\*Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 047790 (GA) 2005 Oct 27 MA NATIONAL NAVAL MEDICAL CENTER 30. Name and address of person who completed cause Joeath (Item 23a) (Type, Print) BETHESDA MD 20889-5600 LCDR MC USNR LEONARD J. KUSKOWSKI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2005

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 0 0 5 35452 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 0251 24 October 2005 /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death **Examiner** Baltimore Maryland )niversit 0 If Under 1 Year | If Under 24 Hrs. | 8. 6. Sex 18 M 2 F 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Dey, 9. Birthplace (State or Foreign **Funeral** Months Days Min. Hours Yrs 24 Director 1 26 MARYLAND none Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health end Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any Injury or other traumatic event, the Medical Exaciner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4005 White Avenue C1 21206 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Stetus 1 Never Merried 2 Married ☐ Yes 2 f Yes, Give 20 No Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Ş Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) none none none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Craig Amos Sharonda Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) University of Maryland Hospital 22 S. Green Street Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 NOther (Specify) in State 21. Signature of Funural Service Licensee Runal A S. Warde State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 mun replications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Enter the dispase, or com or heart failure. List only Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) edical Certification: To Be Completed by Physician/Medical Examiner or Attending Physician: The law requiras that the death certificate be executed as tha buriel-tren Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): is cartificate has been signed by the diractor, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 11 Yes 2 KINO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 💢 No 1 Impatient 2 ER/Outpatient 3 DOA Aftar this eral Director: Aftar thi filled in by the funeral 28c. Injury at Work? 28b. Time of Injury 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. м 1 Yes 2 🗆 No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral C 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SCIJMO Lete 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) S. Greene Tele 22

Registrar **DHMH 16 Rev 6/95** 

State

31. Date filed (Month, Day, Year)

NOV 0 3 2005

32. Registrer's Signature

			riease Type of Print in Black indelible ink. Ensure Al	•		_	ible.	
			State of Maryland / Department of Health and M	lental Hy	gien	enn	15	35453
			- State Registrar Certificate of Death		Reg. N	<u>.</u> U U	, ,	00400
	Dhysiolar		1. Decedent's Name (First, Middle, Last)	2. Date of Dea		ay	Year	3. Time of Death
	Physiciar /Medica		Dorothy Barbara Bennaman	Octobe.	<u>ہ</u> 3		2005	11:05 p.M.
	Examine	r	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4	c. Sount	y of Death	. 1
			Bultimore Washington Medical Center Glen Durnie	,		Hnn	u 41	undel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.  One of the security Number 1	8. Date of Birt (Month, Da 03/21	th y, Year	2	9. Birtho	place (State or Foreign
	Director	- I-	210-34-1371 88	03/21	110	137		MD
	and *	-	Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location	7			1	0d. Inside City Limits
	Aanyl sho	5	MD Anne Arundel Pasadena					1 ☐ Yes 2 No
	vith the Mar	2	10e. Street and Number 10f. Zip Code		10a C	itizen of	What Cour	
	with a c	5	8767 Fort Smallwood Road 21122			J.S.		, .
-	ours after death with the Maryland rat, or items 23a or 28a-f show Exprined at the multified at the Exprined a	2		ecify Yes or No			ce - Americ	can Indian.
== '		5	Armed Forces? If Yes, specify Cuban, Mexican, Puerto 1 □ Never Married 2 Married 1 □ Yes 2 No	Rican, etc.)			ack, White,	
2500 9036	hours after tural; or Ite		3 ☐ Widowed 4 ☐ Divorced   If Yes, Give   1 ☐ Yes 2 ☐ No Specify: Year or Dates:			Speci	ify: Wh	ite
000	2 3 1	נע	15. Decedent's Education 16a. Decedent's Usual Occupation	,	16b.	Kind of I	Business/Inc	dustry
₹ <u></u>	i within 72 ho jiene. r than "natur Iru Madical	2	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of work life. DO NOT use retired)	ing				
7	d with	5	12 Assembly		Вс	x E	Tacto	ry
g Q	be filed that Hygie od other is event.	וע	17. Father's Name (First, Middle, Last)  18. Mother's Name	e (First, Middle,	Maide	n Suma	me)	
Ø <u>ē</u>	should be ind Mental s marked o umetic eve	2	James Schultz Mary	Helen	Svo	bod	da	
Amaryland 21215-	s 1 and 2 should f Health and Mer fem 27 is marke other traumetic	1	19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rur	al Route Numbe	er, City	or Town	n, State, Zip	Code)
-	C - N -		Raymond E. Bennaman, Jr. 8767 Fort Smallwoo	d Rd.,	Pa	asac	dena,	MD 21122
Baltimore,	0 0	1	20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. l	_ocation	- City or To	own, State
~8.Ĕ	permit. Pages Department of Importent: If It any injury or o	1	'4 Donation 5 Other (Specify) Glen Haven Mem Pk 11/	03/05	G16	en I	Burni	e, MD
alt	permit. Pag Department Importent: I any injury o ance.	Ì	21. Signature of Experal Service Licensee 22. Name and Address of Facility G.	J.Gonc	e I	rune	eral	Home, PA
m	90 = 90	1	169 Riviera Dri	ve, Pa	sac	lena	a, MI	21122
	- 3		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory ar	rrest,			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Lung Cancer					Onset and Death
	/Medical		resulting in death)  Due to (or as a consequence of):					
	Examiner		Sequentially list conditions.					
	executed in and ial-transit	2	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
	and trans	<u> </u>	that initiated events c.					
760,			resulting in death) Last Due to (or as a consequence of):					
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9 ×	Physicien: The law requires that the death certificate this certificate has been signed by the attending phyral director, page 2 should be detached for use as the	Med	IF FEMALE: 23c. If yes, outcome of pregnancy		Ţ			
Вох	ath c	a	in the past 12 months?				ate of delive lonth	Pry Year Year
P.O.	d by the attending	Sic	1 Yes 2 No 9 Unknown 9 Unknown					
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<u>=</u>	icate ha			1 ☐ Yes	2 <b>)</b> (N	io	1 Yes	2 No
Z:	sicien: The certificate irector, pag	n n	25. Was case referred to medical examiner?  Hospital: 1 Proceedings 20 SP/Outsetiest 20 Doc Other: 40 Number 14 December 20 Doc Other: 40 Number 14 December 15 Doc Other: 40 Number 14 December 15 Doc Other: 40 Number 14 December 15 Doc Other: 40 Number 14 December 15 Doc Other: 40 Number 15 Do					
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n	ng ne liter		1 Natural 5 Pending (Month, Day Year) Injury Work?	200. Describe i	now mj	ary occu	11180	
Division of Vital Records,	Attending in death. sector: Alter by the fune	2	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street factory office	28f. Location (5	Street a	and Nun	ber or Rum	al Route Number,
Θ	after Dire	Certification	4 Homicide determined building, etc. (Specify)	City or Tov	wn, Sta	te)		
	spite		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the	cause(	s) and n	nanner as s	tated.
	To the Hospitel or Attendii within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	red at the time,	date a	nd place	, and due to	the cause(s)
_	To th Within Somp	ME	29b. Signature and title of certifier 29c. License number				ed (Month,	
	in		1 Hen I Tran MD D027415		00	130	, 200	5
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				-	
	10	1	BAltimore Washington Medical Center.	Glen !	Bu	RN	اح ا	
	State	е	31. Date filed (Month, Day, Year) 32. Registrar's Signature					
	Registra	r	NOV 0 3 2005 > Mayor 15 Specific					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 5 1 = Stete Registron Amend Item #10e Per FH G849 Per fig 9 gf Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year october HAROLD **BLOCK** 1200 PMM 31 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SinA. Hospital of BALL more B+1/c If Under 24 H/s. N/A 5. Social Security Number 7. Age (In yrs. last birthday, Year Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F 71 215-30-3512 Yrs MD Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examinar must be notified at Completed by Funeral Director 1 ☐ Yes 2 No CARROLL FINKSBURG 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Lot items 23a or 2551 BALTIMORE BOULEVARD <del>O LI</del>T 47 21048 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 XXYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married ō WHITE 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) QUALITY CONTROL ELECTRONICS ALLIED SIGNAL of Health and Mental Hygie I Item 27 Ie marked other r other traumatic event, II Baltimore. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be s 1 and 2 should be fi f Health and Mental H tem 27 te marked ott BLOCK BESSIE MARKOW PAUL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21048 ELIZABETH BLOCK / WIFE 2551 BALTIMORE BOULEVARD, LOT 47 - FINKSBURG, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages ŏ 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any njury or once. 4 ☐ Donation 5 ☐ Other (Specify) BETH HAMEDROSH HAGODOL 11/02/2005 ROSEDALE, MD f Funeral Service License 21. Signal 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications but caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pancrutic **Physician** disease or condition resulting in death) Carchan 3 Mas /Medical Due to (or as a consequence of): Examiner CArc. 10 Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury r as a consequence of): Examine burial-transit or Attending Physician: The law requires that the death certificate be executed Kend Cell that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medicai useas IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No certificate has lirector, page 2 s autopsy performed? (es 22 No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural To the needs after death.
To the Funeral Director: All 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide entifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Imaginal Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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2005

32. Registrar's Signature

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29d. Date signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 11:30 а. м John Francis Brown, Sr. October 25, 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Laurel Laurel Regional Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** 1 M 2□F Days Hours Director 216-30-9516 January 25, 1924 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "naturel", or Items 23e or 28e-1 show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Prince Georges Laurel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20708 U.S.A 9000 Briarcroft Lane withIn 72 hours after death Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Manufacturing Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Forklift Operato 2 should be filed w and Mental Hygier is marked other th unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Irene O'Neil Carl Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 is m any injury or other treum 9000 Briarcroft Lane Laurel, Maryland 20708 Wife Ms. C. Viola Brown 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3 Removal from State 10/27/2005 Ellicott City, Maryland 4 □ Donation 5 □ Other (Specify) Good Shepherd Cemetery 21. Sign fure of uneral/Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. Munkelle 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Congestive Heart Failure
Due to for as a consequence of): years /Medical Examiner Coronary Artery Disease Years Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of been signed by the attending physician and should be detached for use as the burial-transit certificate be executed Aortic Insufficiency year that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medicai 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 Yes 2X No 1 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Certification: To 1 ☐ Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 MNo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 1X Naturai 5 Pending death. 1 ☐ Yes 2 ☐ No investigation the f 2 Accident within 24 hours after deal To the Funerel Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide after Hospitel 29a. Certifier tX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43237 October 25, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laurel, MD MD 14201 Laurel Park Dr. Suite 102 Pau1 Armstrong, 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar NOV 0 3 2005

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieneo or

			1 - For State Registrar	State of Maryl		artment of H <i>rtificate of L</i>		Reg	2 U U U	35456
	Physici /Medic		Decedent's Name (First, Middle, Last	Dolores E	Budden			Date of Death     Month     Octob	Day Year Der 26, 2005	3. Time of Death 5:45 p.
-	Examin Funeral		5. Social Security Number 6. S	ord Place Assisted	rs. last birthday)		Location of Death  Col  If Under 24 Hrs.  Hours Min.	umbia  8. Date of Birth (Month, Day, )	4c. County of Death	oward place (State or Foreign intry)
×.	Director		156.16.3422           Usual Residence of Decedent           10a. State         10b. County	- 01	Yrs.			April 24, 1		New Jersey  10d. Inside City Limits
	be filed within 72 hours after deeth with the Maryland it all typiene.  ad other than "netural", or items 23a or 28a-f show strong the mailling at swent, the Madical Exercipal robat be notified at	ai Director	New Jersey Bur 10e. Street and Number 1018 Wall Street	lington		Edge 10f. Zip Code	ewater Park 08010	100	g. Citizen of What Cou	
0000	hours after dee urel', or items al Execution to	d by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Oecedent Ever in Armed Forces  1  Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cubar 1 Yes 2 No	Specify:		14. Race · Amer Black, White Specify:	, etc. White
-017171	ted within 72 I tygiene. her then "net nt, the Mad F	Completed	15. Decedent's E. (Specify only highest gra Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired,	during most of worki ecretery	ng		vernment
aryiane	ed its o	To Be		Lawrence	19b. Maili	ng Address (Street a	18. Mother's Name	Eth	el Haines City or Town, State, Zi	p Code)
iore, M	and eelth m 27		Ms. Ethel Adams  20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Specification)	Removal from State	<ul> <li>b. Place of Dispo cemetery, crea</li> </ul>	osition (Name of matory or other place	9)		Jersey 08010 Oc. Location - City or T	
Dalillio	permit. Pages 1 Depertment of H Important: if Itel eny injury or ott		21. Signature of Furieral Service Licer  23a. Part 1. Errier the disease, or comshock, or heart failure. List only	isee		wood Cremat 2. Name and Addres Slack F 3871 O	s of Facility		Trenton, N	
	Physician /Medical		23a. Part1. Errier the disadse, or com shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	plications that caused the done cause on each line.  a	Den	rentia		•		Approximate Interval Between Onset and Death
/ '00/0	physicien and must see the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as a condition of the co	Sense sequence of):	ne Co.	nemi	r eslase	,	
O. BOX 60	The law requires that the death certificate be executed are hes been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  Oo 9 Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time 9 Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
cords, r.	equires that t sen signed by louid be detac	ρ	Part II. Other significant conditions of	ontributing to death but not	resulting in the u	nderlying cause give	on in Part I.	23e. Did toba	cco use contribute to to	
ומו חפני	in: The law rificate hes boor, page 2 sh	e Completed	25. Was case reterred to medical				26. Place of Death		ed? prior to co death? dNo 1 ☐ Yes	opsy findings available omptetion of cause of
NISION OF A	To the Hospital or Attending Physicien: The law requires that the death certific Within 24 hours lefter death. Within 24 hours lefter death. Completely filled in Dy the funeral director, page 2 should be detached for use as	Certification: To B	examiner?  1  Yes No  27. Manner of Death Natural 2  Accident 3 Suicide 6 Could not b	28a. Date of Injury (Month, Day Year		f 28c. Injury Work M 1 \( \)	4 Nursing Horat	me 5 Resident	ce 6 Other (Speci	
2	dospital or A thours efter uneral Dire ely filled in by		(Check only 2 Medical Exam	building, etc. (Sp ysician: To the best of my niner: On the basis of exam	ecify) knowledge, deat	h occurred at the tim	e date and place	City or Town,	State)	tated
	To the I within 2. To the I complet	Medical	29b. Signature and title of certifier	and manner stated.		29c. License	number	290	d. Date signed (Month	Day Year)
	1		30. Name and address of person who	10 5005.	Signa	Print Bell	Canl	Clau	lissille!	170 2005 20 20029
	Sta Registr		31. Date filed (Month, Day, Year)  NOV 0 3 2	32. Registrar's Si	gnature	ball				

State of Maryland / Department of Health and Mental Hygiene 05 35457 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year Wilhelmina Marie Corrado October 24, 2005 12:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Egle Nursing & Rehab Center Lonaconing Allegany If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□ M 2√ F Yrs. 579-48-2972 Dec 4, 1922 Germany Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2√☐ No MD Allegany Mt. Savage 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 57 Jackson Street 21539 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Yes 2 No Specify: <u>≽</u> Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ Aloise Engl Wilhelmina Kresser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gunter Corrado/son P.O. Box 583 12702 Old Row Road Mt. Savage, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 
☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee
Ronald S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201
Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Carrinama Breast Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Diabites, Congestive heart Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown δ Hyporten Sron. Demarka 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? POSS meta Statie Disease from CA. Breast 2 1 No 1 🗆 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 DNatural Certification: 28a. Date of Injury (Month, Day Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar nales

NOV 0 3 2005

32. Registrar's Signature

31. Date filed (Month, Day, Year)

**Funeral** 

Director

item 27 is marked other than "neturel", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at

Hygiene.

permit. Peges 1 end 2 should be f Depertment of Health and Mental I Important: If Item 27 is marked of eny injury or other traumatic eve

**Physician** 

the death certificate be executed the attending physician and hed for use es the burial-transit

Division of Vital Records, P.O. Box 68760,

/Medical Examiner

> page 2 hes

> > director,

this certificate

After this funeral d

To the Hospital or Attending within 24 hours efter death.

To the Funerel Director: Afte completely filled in by the fun

Hospital or Attending Physician:

Maryland 21215-0020

altimore,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 15 For State Registrer Certificate of Death 2 Date of Death 3 Time of Death Decedent's Name (First, Middle, Last) ANNON **Physician** 2:15AM OCTOBER /Medical 4b. City, Town or Location of Death 4c. County of Death **Examiner** BACTIMORE NURSING Home If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Y. MAY 24, I 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) **Funeral** 1□M 2MF Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show Examiner must be notified at 1 Yes 2 No by Funeral Director PACTI MORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5435 Items 23e . Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 Newer Married 2 Married Baltimore, Maryland 21215-0036 "netural", or 1 ☐ Yes 2 1 No 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HEALTH CARE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) To Be DIVGLASS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANKFORD AVE. PERCELL (GRAND-DAUGHTER) item 27 I 5635 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any injury or ot ance. 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 11.4.05 TRIANGLE, CEMETERY VIRGINIA <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 21. Signatule of Funeral le vice Licensee 22. Name and Address of Facility VAVOHN C. GREENE FUNEKAL POME YORK ROAD BACTIMORE, MARYLAND 2013 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Qo not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner Husertenger Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-transit ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 menths?
1 Yes 2 WNo 23d. Date of delivery 3 Ectopic pregnancy Month Day Vear 5 Other (specify) P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Denknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 Yes or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No Certification: To this 28c. Injury at Work? 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Watural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death. 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funerel D 29a. Certifier 1 😿 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

State

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Rugal

10/31/05

QM?

1600 West

32. Registrar's Signature,

PRENCE S

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salvja

NOV 0

31. Date filed (Month, Day, Year)

		1	State of Maryland / Department / Department / Department / Department / Department / Department	artment of Health and M rtificate of Death	lental Hygien		35459
7	Physicia	an	1. Decedent's Name (First, Middle, Last)  Adam A. Cardinale		2. Date of Death Month D Oct 27, 20	ay Year	3. Time of Death 20:58 P <sup>M</sup>
	/Medic Examin	a 1	4a. Facility Name (If not institution, give street and number)  Southern Maryland Hospital	4b. City, Town, or Location of Death Clinton	4	c. County of Deat Prince G	h
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	0.00	hplace (State or Foreign buntry) Shington DC
Baitimore, Maryland 21215-0035	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland. Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "naturel; or iteme 23a or 28a-f ehow eny injury or other traumatic event. It is Madical Examinar must be notified at ODEs.	To Be Completed by Funeral Director	10e. Street and Number  6908 Westchester Court  11. Marital Status  1	Camp Springs  101. Zip Code  20748  Was Decedent of Hispanic Origin? (Splif Yes, specify Cuban, Mexican, Puerto 1 The Yes of Yaman Specify:  Jent's Usual Occupation kind of work done during most of work DO NOT use retired)  eman	ecfty Yes or No-Rican, etc.)  ing  16b.  ing  Fe (First, Middle, Maide SSO al Route Number, City Camp Sprir Date 2005 ery Suee Funeral	PEPCO an Sumame) or Town, State, and Sign, MD 20 Location - City or 11tland, Home, Inc.	ates  nican Indian, e, etc.  ite  //industry  ///  ///  ///  ///  //  //  //  //
Division of Vital Records, P.O. Box 68760,	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicien and make completely filled in by the funeral director, page 2 should be detached for use as the burial-transit and process the process of the process	Medical Certification: To Be Completed by Physician/Medical Examiner	Due to (or as a consequence of):    Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last   Due to (or as a consequence of):    Due to (or as a consequence of):	26. Place of Deal  26. Place of Deal  27. A state of Deal  28. Injury at Work?  M 1 Yes 2 No  reet, factory, office	23e. Did tobacce  1 Yes  24a. Was an autopsy performed: 1 Yes 2 1 th (Check only one)  28d. Describe how in  28f. Location (Street City or Town, State and due to the cause red at the time, date a	23d. Date of de Month  o use contribute to 2 No 3 P  24b. Were a prior to death?  1 Yes  6 Other (Spengury occurred  and Number or Rate)	livery Day Year  o the cause of death?  robably 4 Unknown  utopsy findings available completion of cause of s 2 No  porfy)  ural Route Number,  s stated. e to the cause(s)
<b>√</b>			30. Name and address of person who completed cause of death (Item 23a) (Type	DISSYS ED LINE CENT	50 (1)A(	WAR A	28, 2003 W. D.COR
<u> </u>	St Regist	ate rar	31. Date filed (Month, Day, Year)  NOV 0 3 2005  32. Registrar's Signature		02 00,10		

			For State Registrar	State of N	Maryland	d / Depa	artmer	t of H	ealth a Death	ind M	lental Hy	gierje Reg. No.		3546	0
3	Physici	an	1. Decedent's Name (First, Middle, La	Franklin	Edward	d Con	win				2. Date of D Month	Day		3. Time of D 6:15 a.	
	/Medic	16	4a. Facility Name (If not institution, gi			4 0011		Town, or	Location o	f Death	U(		29, 2005 County of Dea		
*	Examir	er	, , , , , , , , , , , , , , , , , , , ,	338 Adams							Burnie			ne Arundel	
	Funeral		Social Security Number 6.	Şex, 7.	Age (In yrs. ia	st birthday)		r 1 Year	If Under	24 Hrs.	8. Date of Bi (Month, D	rth		rthplace (State or I	Foreign
1	Director	10	367-52-3562	1 M 2□F	53	3 Yrs.	Months	Days	Hours	Min.				Michigan	
	D >	3	Usual Residence of Decedent  10a. State 10b. County		100 City	Town or Lo					August	12, 13	JZ		1:-:-
	anyla ehov	7	134		Toc. City,	, TOWN OF LC	cation							10d. Inside City 1 ☐ Yes 2	,
	28a-1	Director	Maryland Ann  10e. Street and Number	e Arundel			124 7		en Burr	nie		40- 07	zen of What C		7
	a or	ā					101. 21	Code	210	161		rog. Citi		,	
	s 23	Funeral	338 Adams Ct.	12. Was Decede	nt Ever in U.S.	13	Was Doce	dent of His			cify Ves or N	^-	14. Race - Am	,S.A.	
	ter d	Fun	1 Never Married 2 Married	Armed Force	s?		If Yes, spe	city Cubar	n, Mexican	, Puerto	cify Yes or N Rican, etc.)	-	Black, Whi		
8	urs al	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	18	971 992	1 🗌 Yes	2 <b>□x</b> No	Specify:				Specify:	White	
5-0036	filed within 72 hours after death with the Maryland Hygiene. other then "naturel", or Reme 23a or 28a-f ehow ent, the Madical Examinatinust be nuillisd at	Completed	15. Decedent's E (Specify only highest gi	Education		16a. Dece	dent's Usu	al Occupa	ition u <i>ri</i> ng most	of worki	ing.	16b. Ki	nd of Business	/Industry	
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<u>\Z</u>	should be ind Mental I	ပု		Dale Corwin				ļ					Bulmer		
Maryland 2121			19a. Informant's Name/Relationship				-						r Town, State,	Zip Code)	
	s 1 and if Health Item 27 other tr		Mrs. Linda D. Corw  20a. Method of Disposition	in W	ife 20b Pla	ace of Dispo			. Glen I		, Marylan		1 ecation - City or	Town State	
altimore,	Pages nent of h int: If Ite		1 Burial 2 Cremation 3		1 00	metery, crei	natory or	other place	9)			200. LC			
Ξ	rtmer rtent njury		4 Donation 5 Other (Spec 21. Signature 1 Ineral Service Lice	-	<i>F</i>	Arlingtor			netery s of Facilit		15/2005		Arlingto	on, Virginia	
Ba	permit. Pages Department of Importent: If II eny Injury or o		21. Signature of Authoral Solvice Cick	111/1/1/1	11,900	3				•	PA				
A.	* * *		23a. Partf. Enter the disease, of con-	polications that caus	sed the death	Do not en	er the mo	3871 C	Id Colu	mbia	Pike Ellice	ott City	, MD 2104	3 Approximate	
9.4			snock, or near failure. Jast ont	y one cause on eacr	n line.									Onset and De	ath
84,	Physician /Medical		fmmediate Cause (Final disease of condition resulting in death)		as a conseque		1914	Care	Chem	4	3436	10		10 mm	145
1	Examiner			Due to (0)	as a conseque	ence or):									
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9	The law requires that the death certificate be executed tte has been signed by the attending physician end oate 2 should be detached for use as the burial-transit	Physician/Medical	fF FEMALE:											L	
Вох	ath ce ttend or us	an/	23b. Was decedent pregnant in the past 12 months?		2 Fetal	death 3[	]Ectopic p						23d. Date of de Month	livery Day Ye	ar
o.	the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnani 9∐Unknowr	tat time of dea	ath 5	Other (s	oecify)					11101111	Day 10	
P.O.	that the de led by the a detached f		Part ff. Other significant conditions	contributing to deat	h but not resul	Iting in the u	nderlying	ause aive	n in Part f		23e Did	tobacco u	ise contribute t	o the cause of dea	ath?
ds,	signed I d be det	d by	Marmia		Pain.		indonyang '	Jagoo givo			3	,		robably 4 ∏Un	
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ğ	has ge 2	ğ	-								24a. Was		prior to death?	utopsy findings av completion of cau	ise of
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₹	Attanding Physicien: r death. ector: After this certifics by the funeral director, I	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	ationt OFF	R/Outpatier		Othe			Check only				
o	ding Phys	<u>ان</u> کو	27. Manner of Death	28a. Date of I	njury 2	28b. Time o		28c. Injury Work	4 🗆 140		28d. Describe		Other (Spe	эспу)	
0	th: Afte	ig I	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Day Year)	Injury	М		? ′es 2 []f	No					
Division of Vital Records,	or Attandente de orte	Certification:	3 ☐ Suicide 6 ☐ Could not determine	d 286. Place of	Injury - At hon		reet, factor	y, office						lural Route Numbe	er,
ā	al or A s efter al Direct	Sert	4 🔲 Homiciae	building,	etc. (Specify)	,					City or To	iwn, State	)		
	To the Hospital or Attanding Physicien: The within 24 hours eiter death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	edical	29a. Certifier (Check only one)  1 Certifying F	Physician: To the beaminer: On the basis and manner	s of examination	vledge, deat on and/or in	h occurred vestigation	at the tim	e, date an inion, deal	d place, i	and due to the ed at the time	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)	
	To th within To th	Me	29b. Signature and title of certifier	-1	Λ.		29	c. License	number			29d. Dat	e signed (Mon.	th, Day, Year)	
•			Don X. M	numb.	X			030	57	3		10-	31-05		
	.Δ.		30. Name and 3 cress of person who	completed cause of	of death (Item :	23a) (Type,	Print)								
	17		Jon K Minf	116	065	14:47	P. P.	tox	ent	Par	Kwail	Col	n ridmi	NP 210	4 4
180	Sta		31. Date fifed (Month, Day, Year)	2005 32. Reg	strar's Signatu	ure	1	of a							
A.L	Regist	ar	NOV 0 3	7001	STAR J	A.F	STATE OF								

			1 - For State Registrar	State of M	aryland / I	Departmer <i>Certificat</i>	nt of H	lealth a	and Me		giene Reg. No.	05	35461
ı	Physici	an	1. Decedent's Name (First, Middle, I Walter	<sub>ast)</sub> Frank	Choi	norvalet				. Date of Dea		1,20°	3. Time of Death
TO	/Medic		4a. Facility Name (If not institution, g			nowski	Town o	r Location of		ctobe		County of D	
-	Examin	er	Johns Hopkins				-	imore			46.	n/a	, sau
	Funeral		Social Security Number 6	Sex 7. As	ge (In yrs. last bi		r 1 Year	If Under Hours		. Date of Birt	h Vear	-	Birthplace (State or Foreign
п	Director		212-09-1914	1⊠M 2□F	85	Yrs.	Days	Hours	D D	Date of Birt (Month, Da ec28,	191	9 Ma	aryland
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Location							10d. Inside City Limits
	Mary First	tor	Md n/a			Balti	more	2					Y Yes 2 No
	or 28s	lrec	10e. Street and Number				Code	-	-		10g. Citi	zen of What	t Country?
	23a	ral	16 South Ellw	ood Avenı	ie .		212	224				USA	77/
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 Is marked other than "natural", or Items 23a or 28a-f ahow or other traumatic event, the Madical Exerticant he multipled at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces  1	?	13. Was Dece If Yes, spe 1 \( \subseteq Yes		lispanic Ori an, Mexicar Specify:		y Yes or No- can, etc.)		Black, W	American Indian, White, etc. White
5-0	72 ho	eted	15. Decedent's (Specify only highest of		16a	. Decedent's Usu (Give kind of wo	al Occup	ation durina mos	st of working				ess/industry
2	vithin ne. hen.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	(Give kind of wo							nouse
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Maryland	d 2 should be filed within h and Mental Hygiene. 7 Ia marked other than traumatic event, the Me	To Be	Stanislaus C	hojnowski				Fra	ances	Witk	OWS	ki	
Mai	d 2 st th and 17 lan traun		19a. Informant's Name/Relationship			D. Mailing Address							
	Health tem 27 other tr		James W. Choj 20a. Method of Disposition	nowsk1/sc	20b. Place of	20 Foy of Disposition (Na.	me of		101SO Dat				or Town, State
9	Pages nent of I int: If its iry or o		1 X Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe			ery, crematory or d anisla			1/3/	05	Bal	timor	ce, Md.
Baltimore,	perrit. Page Department Important: If any Injury o		21. Signature of Funeral Service Lic			22. Name a	nd Addre	ss of Facill	Kacz	orows	ki	Funer	ral Home, PA 21224
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	implications that cause by one cause on each I	d the death, Do	not enter the mod	de of dyin	g, such as	cardiac or r	espiratory ar	rest,		Approximate Interval Between
М	Physician		Immediate Cause (Final disease or condition	Acute	Renal	Failu	re						Onset and Death 5 Days
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):							- 3/2 - 5/2
)š.		er	Sequentially list conditions if any, leading to immediate	b. Conge	stive a consequence	Heart i	Fail	ure					i+ Years
V	uted d ansit	Examiner	Securities ly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		ary Ar	tery D	isea	ıse					5+ Years
o,	be executed sician and burial-transit	Еха	resulting in death) Last	c. Due to (or as	a consequence	of):							
8760,	ate be ex hysician the buria	dlcai		d.									
9	ding p	/Med	IF FEMALE:	220 Huon autoome	of prognancy						- 1		
D. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal death	3 □Ectopic p 5 □ Other (s)		′			2	3d. Date of Month	delivery Day Year
P.0	res that the digned by the be detached		Part II. Other significant conditions	s contributing to death I	out not resulting	in the underlying o	cause giv	en in Part I		23e. Did to	obacco u	se contribut	e to the cause of death?
of Vital Records,	quires in sign	Completed by	Chronic Obst	ructive F	ulmona	ry Dise	ease	2		1 🗆 1	es 2[	□No 3⊉	Probably 4 □Unknown
000	e law requir has been si je 2 should	plet								24a. Was		24b. Were	autopsy findings available
E E		Com				-				autop perfo 1  Yes	rmed?	death	
/ita	yslcian: Th nis certificate director, pag	Be (	25. Was case referred to medical examiner?					26. Place	e of Death (	Check only o			
of \	Physic this c	<u>С</u>	1 ☐ Yes 2 🔀 No  27. Manner of Death			utpatient 3 Do		4 1140		5 🗆 Resid			Specify)
	ding Phy h. After this funeral o	tlon	1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ay Year)	Time of Injury	28c. Injun Wor	yat k? Yes 2 □		d. Describe h	iow injur	occurred	
Division	I or Attending Physician: after death. Director: Atter this certific I in by the funeral director,	fica	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of In	jury - At home, fa	arm, street, factor		.00 20	_	Location (S	Street and	d Number or	r Rural Route Number,
Ö	in Line	Certification;	4 Homicide	building, e	tc. (Specify)					City or Tou	vn, State,		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical (	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis of and manner s	of examination ar	e, death occurred nd/or investigation	at the tin	ne, date an pinion, dea	nd place, and ath occurred	d due to the o	cause(s) date and	and manner place, and	r as stated. due to the cause(s)
	To the within To the Comp	M	29b. Signature and title of certifier			29	c. Licens	e number			29d. Date	signed (M	onth, Day, Year)
•			) Hog,	mEDICAL D	6 CTOR		D006	1901	-		Oct	ober	31, 2005
	10		30. Name and address of person who William Hung,	M.D. 494	death (Item 23a) 0 East	(Type, Print) ern Ave	enue	Bal	timo	re, M	ary	land	21224
ė.	Sta Registi		31. Date filed (Month, Day, Year)	2005 32. Regist	car's Signature	hours							

_			1 - StateAmend Item 28	State of Maryland / E8b&Unpend Item 23a	Department of Health and 1778 a f Certificate of Death	Mental Hy 349 11-7- tas	giene 05 052 05 Reg. No.	35462
	Physici	an	Decedent's Name (First, Middle, L.			2. Date of De	ath	3. Time of Death
	/Media	cal	DAVON	LAMONT	EADY	OCTOBE	$\mathbb{R}$ $\stackrel{\text{Day}}{29}$ , $2005$	4:00P. M
	Examir	ier 	4a. Facility Name (If not institution, git UNIVERSITY HOSPIT	· ·	4b. City, Thown, or Location of De BALTIMORE	eath	4c. County of Death	
88/10	Funeral Director		5. Social Security Number 6.  213-17-5075  Usual Residence of Decedent	Sex 7. Age (In yrs. last bin		in. (Month, Da	y, Year Cou	place (State or Foreign ntry) RYLAND
	aryland show	_	10a. State 10b. County	10c. City, Town		,		10d. Inside City Limits
	the Ma	Director	MARYLAND BA	LTIMORE	RANDALLSTO	ww		1 ☐ Yes 2 No
	3a or	I Dir	8814 G111	( 11) A-V	10f. Zip Code	3.3	10g. Citizen of What Cou	ntry?
	ems 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No	- 14. Race - Ameri	can Indian,
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f show is Medical Examinar musi be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 XNo If Yes, Give Year or Dates:	1 ☐ Yes 2⊠No Specify:	erto Alcan, etc.)	C	etc.
15-(	n 72 hours "natural", edical Ext	ete	15. Decedent's E (Specify only highest gi	ducation 16a.	Decedent's Usual Occupation (Give kind of work done during most of ville. DO NOT use retired)	vorking	16b. Kind of Business/In	ndustry
212	be filed within 7 ital Hygiene. Id other than "n	Completed	Elementary/Secondary (0-12) 12+4 GRADE	College (1-4or 5+)	TACHINE OPER		NATIONAL CO.	ATING INC.
Maryland		Be	17. Father's Name (First, Middle, Las			lame (First, Middle,		
17	2 should t and Ment ie marked sumatice	은	19a. Informant's Name/Relationship	RICKS	Mailing Address (Street and Number or		TAE EA	
	and 2 s lealth ar m 27 ie		HATTIE MAE EA		814 GILLY WAY	0	LLSTOWN, SIZE, ZIP	211.33
Baltimore,	Pages 1 and 2 should hent of Health and Mer int: if item 27 ie marke iry or other traumatic		20a. Method of Disposition 1. ☐ Burial 2 ☐ Cremation 3 [	20b. Place of	Disposition (Name of , crematory or other place)	Date	20c. Location - City or To	own, State
Ē	Pa anti-		4 □Donation 5 □ Other (Special Signature of Funeral Service Lice	WEST	ERNSTAR 11-	-05-05	CATONSVIL	LE, MD.
Ba	permit. Deperte importe sny inj		Lietich L	1. Williams	22 Name and Address of Facility A JOSEPHH. A. 2140 N. FULTON	PROLUIN CK	ALTO, MO.	21217
*.	2. 5. 20		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the death. Do not one cause on each line.	ot enter the mode of dying, such as card			Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in dealh)		the left thigh wit	th compli	cations	Onset and Death
	Examiner		Constant the line constitution	Due to (or as a consequence of	1):			
	pe sit	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	f):			
,	execut n and ial-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence of	f):			
8760	cate be executed physicien and the burial-transit	dical	(	d				
9		Med	IF FEMALE:	-				
P.O. Box	res thet the death certifi igned by the attending be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death  4 Pregnant at time of death  9 Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delive Month	ery Day Year
	w requires that the been signed by th should be detache	Ď	Part II. Other significant conditions	contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did to	obacco use contribute to the	ne cause of death?
Division of Vital Records,	> 0 0	Completed				24a. Was autop	rmed? prior to condeath?	psy findings available mpletion of cause of
ital	ilan: ortifica ctor, p	BeC	25. Was case referred to medical examiner?		26. Place of D	eath (Check only o		2 No
of V	Physician: this certific ral director,	2	1 X Yes 2 □ No		patient 3 DOA Other: 4 Nursing		lence 6 Other (Specifi	v)
ouo	ding F h. After funera	Certification:	27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigatio		jury <b>P</b> Work?		ow injury occurred	
visi	Atten	ifica	2 Accident investigatio 3 Suicide 6 Could not be 4 X Homicide determined	28e. Place of Injury - At home, fare	1 ☐ Yes 2 🛣 No		t was shot Greet and Number or Rura rn, State) 3400 BI	LRoute Number
Ö	ital or irs efte rai Dir led in	Cert		Street Street		Baltimo	re, Maryland	
	To the Hospital or Attending Physician: The law within 24 burus effer death. To the Funeral Director: Attent this certificate has completely filled in by the funeral director, page 2.	ledicat	29a. Certifier (Check only one)  1 ☐ Certifying Pl 2 ☐ Medical Example 1	nysicien: To the best of my knowledge, miner: On the basis of examination and and manner stated.	death occurred at the time, date and plat for investigation, in my opinion, death oc	ce and due to the	Susa(s) and manner as of	atod
_	To the To the Comple	Me	29b. Signature and title of certifier	and mainler stated.	29c. License number		29d. Date signed (Month,	Dey, Year)
			· /_	M	O.C.M.E.	(	OCTOBER 30,2	005
	The state of the s		30. Name and address of person who	completed cause of death (Item 23a) (T		BALTIMO	RE MARYLAND	21201
. *	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	and to			
DHA	Registr		NOV 0 3 200	5 See See See See See See See See See Se				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item 5 per fh 9851 1-9-06 vt.
State of Maryland / Department of Health and Mental Hygiene 15 35463 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 28 05 6:52A. M Franklin 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, 03 03 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 3785-12-9816 Months 1 ☐ M 2 🖾 F South Carolina Yrs. 93 12 <del>-5985</del> Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Silver Spring 1X Yes 2 □ No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 USA 1812 Middlevale Terrace 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bfack, White, etc. 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ZNo Specify: Specify: Black 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Elevator Operator IISA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jack Browning Eugenia Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Frederick/Daughter 1812 Middlevale Terrace Silver Spring, MD. 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 11-4-05 Fort Lincoln Cem Brentwood, MD. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility MArshall's Funeral Home 21. Signature of Funeral Service Licensee 4217 9th. St. N.W. Washington, D.C. 20011 Mashall 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Congestive heart failure Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualty for as a consuguence off Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes Mellitus type II 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X ☐ Unknown Peripheral Vascular Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan 1 ☐ Yes 21 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Inpatient 1 ☐ Yes 2 🔀 No 2 X ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 XNatural 5 Pending investigation 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

/Medical Examiner The law requires that the death certificate be executed Box 68760. of Vital Records, P.O. Division

attending physician and for use as the burial-transit the detached δ has certificate To the Hospital or Attending Physician: this death. after death Director: d in by the f within 24 hours a To the Funeral I completely

**Physician** 

/Medical

Examiner

**Funeral** 

Director

**show** 

r then "natural", or items 23a or 28a-f shov It a Medical Examiner must be notified at

7 is marked othe traumatic event,

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event, 2008.

**Physician** 

Director

Funeral

Completed by

Be

Examiner

Physician/Medical

Be Completed by

2

Certification:

Medical

29a Cartifier

(Check only

MD

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State

Registrar

29b. Signature and title of certifier 0 1 LW 30. Name and address of person who completed - use of death (ftem 3a) (Type, Print)

29c. License number

Goods)

1 2 Certifying Physiciant To the best of my knowledge death occurred at the time-date and place, and due to the dates(s) and marrier as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

October 28, 2005 D52261

Segal, 1500 Forest Glen Rd. Silver Spring, MD. 20912 Dr. Alan R. M.D.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

and manner stated

State of Maryland / Department of Health and Mental Hygiene 15 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 30 Oct 6: 24PM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore niversity of Maryland Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1 M 2 F Months 213.76 4984 Director MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 5,4. 21060 Funeral "naturel", or iteme Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 2 No 1 Never Married 2 Married 1 Tes 2 If Yes, Give Specify: 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced SHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if item 27 ie marked other then any injury or other traumatic event, the Mesonice. Elementary/Secondary (0-12) College (1-4or 5+) DAITRESS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, William EDGAR HoofNAGLE
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherry Quinlan 4 ELEANOR AVE. L 40.21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State AYVIEW CREMATORY 5 Other (Specify) 4 □Donajin 11-2-05 21. Signatur eral Service Licenses 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) **Physician** Gram negative rod bacteremia /Medical Due to (or as a consequence of): Examiner Preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) Records, P.O. the detached 9 Unknown 9 Unknown ۾ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Stage renaldisease 1 Tes 2 No 3 ☐ Probably 4 ☑ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No peripheral vascular disease 24a. Was an severe autopsy performed Division of Vital 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of After t 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) nell brada MD 16646 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UHMS 22 South Greene St Baltimore, MD 21002 Chenell Dangdee 32 Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 3 2005 Registrar

			For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of H ertificate of I		Reg		35465
ı	Physici	an	1. Decedent's Name (First, Middle, Las Richard E. Getti	er, Sr.				2. Date of Death Month	Day Year 27 2005	3. Time of Death 935 A M
	/Medic Examin Funeral Director	er	4a. Facility Name (If not institution, give GENCS/S CATO 5. Social Security Number 6. S 219-22-4732	NMANE	(In yrs. last birthday 77 Yrs.	Balti	Location of Death MOTE  If Under 24 Hrs. Hours Min.	8. Date of Birth J. June 20	4c. County of Death N/A 9. Birth	place (State or Foreign
	D	or	Usual Residence of Decedent  10a. State 10b. County  MD N/A		10c. City, Town or L Baltimo					10d. Inside City Limits 1 ∰es 2 □ No
	n with the N 3a or 28a-	Funeral Director	10e. Street and Number 1055 Jack Place			10f. Zip Code 2122.	5		J. Citizen of What Cou	untry?
350	iges 1 and 2 should be filed within 72 hours after deeth with the Maryland it of Health and Mental Hyglene.  If it item 27 is marked other than "natural", or items 23s.or 28s-f ehow or other traumatic event, the M. Orcal Exam ner must be notified at or other traumatic event, the M. Orcal Exam ner must be notified at	Ď	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:	ever in U.S. 13	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No		ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
Baltimore, Maryland 21215-0036	within 72 hou ene. than "nature be weden E	Completed	15. Decedent's Ec (Specify only highest grade) Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5	(Giv	edent's Usual Occup e kind of work done o DO NOT use retired hanic	ation during most of work t)	ing	b. Kind of Business/I	ndustry
langz	uld be filed within fental Hyglene. rked other than ' tic event, Ite W.	To Be Co	17. Father's Name (First, Middle, Last, Earl Gettier, Sr				18. Mother's Name Ellen V	e (First, Middle, Ma		
, Mary	1 and 2 should be Health and Mental Iom 27 ia marked of other traumatic ev		19a. Informant's Name/Relationship (William T. Gettie		12	28 Greysto	one Rd. A	rbutus, M		
imore	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □  '4 □ Donation 5 □ Other (Specif	y)	Bayview	oosition (Name of ematory or other plac Crematory	10-3	1 <b>-</b> 05 B	saltimore,	
Ball	Departition Depart		21. Signature of Funeral Service Licer	Dr		Name and Addre Ambrose 1328 Sul	ohur Spri	ng Rd. Ar	butus, MD	. 21227 Approximate
68760,	Character be executed /Medical Examiner sthe purial-transit	edicai Examiner	23a. art1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate nause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	a	a consequence of):  Party Cyric  Porty Cyric  A consequence of):	. A Rt Voscula	/			Interval Between Onset and Death  Felix slag J
Box	ath certi stending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnancy	1		23d. Date ol deli Month	very Day Year
rds, P.O.	quires that the de in signed by the e uld be detached t	þ	Part II. Other significant conditions		ut not resulting in the	underlying cause giv	ven in Part I.		cco use contribute to	the cause of death?
of Vital Records,		Completed	,					24a. Was an autopsy performe 1 Yes 26	prior to death?	topsy findings available completion of cause of 2 \sumbox No
	To the Hospital or Attending Physician: Th within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	Certification; To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No  27. Manner ol Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatic 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Inju (Month, Da	y Year) Injury	of 28c. Injur	ner: 4 Nursing Hory at	28d. Describe how	ce 6 □Other (Spec rinjury occurred	
Division	oepital or Attend hours after death uneral Director: ily filled in by the		4 ☐ Homicide determined	building, et			me date and stars	City or Town,		
5	To the Hoepital within 24 hours a To the Funeral I completely filled	Medical	29a. Cartifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis o and manner st	f examination and/or ated.	investigation, in my o	opinion, death occur	rred at the time, date	e and place, and due	to the cause(s)
			30. Name and Press of person who	completed cause of c	leath (Item 23a) (Typ 2711 HA				RE MD	2/227
	St Regis	ate trar	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	de	,			

			1 - For Amend Amend In Registrar Amend In Amend In Amend In Agnes	State of	of Marylar y G891ar	14/2996 11/2996	ytmen 76 Jil 716-41	t of H e-of L	lealth a D <i>eath</i>	and Me	ental Hyg	ieße	005	35461	6
ı	Physicia /Medic	٠.,	1. Decedent's Name (First, Middle Agnes Anges E. Guber		er rn (	<del>5049 11</del>	<del>/V//</del> (		JII		2. Date of Deat Month November		Year 2005	3. Time of Dea 8:45 A	
>	Examin		4a. Facility Name (If not institution	, give street and nu	mber)		4b. City,	Town, or	Location of	_			County of De		
			Charlestown Ca						Caton				B	altimore	
	Funeral		5. Social Security Number	6. Sex 1 □ M 2 1 □ F	7. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day, Jun. 27	Year)		rthplace (State or Fo.	reign
	Director		217-07-0563 Usual Residence of Decedent		0	9 115.				_	Jun. 2/	19	16 M	aryland	
	yland yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Li	imits
	Mar.	ģ	MD Bal	timore			C:	atons	svill	e				1 ☐ Yes X	] No
	th the	Director	10e. Street and Number Maidens			431s	10f. Zip				1	0g. Citiz	en of What C	Country?	
	23a 23a		709 <del>haiden</del> Cho	ice Lane	Apt.	<del>221</del>			2122	8		Uni	ted St	ates	
	tems tems	Funeral	11. Marital Status	Armed F		J.S. 13. \	Was Deced	dent of Hi cify Cuba	ispanic Ori n, Mexicar	gin? (Spec n, Puerto F	cify Yes or No- Rican, etc.)	1	4. Race - Am Black, Wh	erican Indian, ite, etc.	
0000	s afte	by Fi	1 ☐ Never Married 2 ☐ Marri 3 🔀 Widowed 4 ☐ Divorced	ed 1 ⊡Yes If Yes, Gi Year or D	ive	i i	1 🗆 Yes		Specify:					White	
3	hour		15. Decedent		Jales:	16a. Deced	dent's Usus	al Occupa	ation			16b Kin	nd of Busines	c/ledustry	
	in 72	Completed	(Specify only highes	t grade completed)		(Give	kind of wo	rk done d se retired	during mos	t of workin	g	TOD. KIII	id of busines	sindustry	
7 7	d with	E	Elementary/Secondary (0-12)	College (	1-4or 5+)	H	lomema	aker					Ow	n Home	
alla	al Hyg	Be C	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	(First, Middle, I	Aaiden :	Sumame)		
<u>a</u>	Menta	ToE	James E. Haupt						]	Mary	Jane Mi	1ho	11and		
Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If lem 27 is marked other then "natural" or items 23a or 28a-f show any injury or other treumatic event, the Medical Examinar maintible nutified at once.		19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	r or Rural	Route Number	City or	Town, State,	Zip Code)	
2 1,`	and lealth m 27 her tr		James Gubernat	is Son	Tool 1	473 B	ryce	Aver	nue,		lamos,				
5	ges 1 t of H If ite or ot		20a. Method of Disposition  Surial 2 Cremation	3 □Removal from	State	Place of Dispo cemetery, cren			ө)	Da	ate	20c. Loc	ation - City o	r Town, State	
Daltimor	t. Partmen tment: rtent:		4 □ Donation 5 □ Other (S)		Woo	odlawn				11-5-		Wood	dlawn,	MD	
200	Depar Depar Impo any ir		21. Signature di Funeral Service	Licensee	Don't	22	. Name an	d Addres	s of Facilit	y Amb	rose Fu	nera	al Hom	e, Inc.	
	40244		23a. Part1. Enter the disease, or	nomelications that	774						Rd., Ar		us, MD		
į	Physician /Medical		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	each line.	emb	1 fm	4 or dying	g, such as	cardiac or	respiratory arre	sst,		Approximate Interval Between Onset and Deat	th
	Examiner •	<b>L</b>	Sequentially list conditions,	b	(or as a consec										
	acuted ind transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consec										
9/00,	icate be executed physician and s the burial-transit	dicai Ex	resulting in death, cast	d	(or as a consec	quence of):									
Ö	ing ph	0	IF FEMALE:												
O. DOX	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	itcome of pregni birth 2 Feta nant at time of c nown	al death 3	Ectopic pr Other (sp					2.	3d. Date of de Month	elivery Day Year	
ŗ.	that I		Part II. Other significent condition	ns contributing to c	leath but not res	sulting in the ur	nderlying c	ause give	n in Part J.		23e. Did tob	acco us	e contribute	to the cause of death	h?
cords	requires een sign nould be	d by									1 □ Y€	s 24	JNo 3□F	robably 4 Unkn	nown
รู	w rec	Completed									24a. Was a	1	24b. Were a	utopsy findings avail	lable
T T	The law ate has b page 2 st	шо									autops	y ned?	prior to death?	completion of cause	e of
N I G		0	25. Was case referred to medical		-				26. Place	of Death	1 ☐ Yes (Check only on		1 🗀 Ye	s 2□ No	
	≥ .5 D	To B	examiner? 1 Tes 2 No	Hospital: 1 🗆	Inpatient 2	ER/Outpatien	t 3□ DC	A Othe			e 5 ☐ Reside		□Other (Sp	ecify)	
ō	ng Ph Iter th neral		27. Manner of Death  Natural 5 ☐ Pending	28a. Date	of Injury oth, Day Year)	28b. Time of Injury	2	8c. Injury Work			8d. Describe ho				
0	endii eath. or: A the fu	satio	2 Accident investig	ation			М		Yes 2□I	No					
DIVISION	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ned 289. Place	e of Injury - At h ling, etc. (Special	ome, farm, str	eet, factory	r, office		2	8f. Location (St. City or Town		Number or F	Rural Route Number,	
	he Kosp n 24 hou he Funei stetely fil	ledical	29a. Certifier  (Check only 2 Medicel in one)	g Physicien: To th Examiner: On the b and mar	e best of my kno pasis of examina nner stated.	owledge, death ation and/or inv	occurred vestigation	at the tim	ne, date an pinion, dea	d place, ar th occurre	nd due to the ca d at the time, da	use(s) a ate and	and manner a place, and du	s stated. le to the cause(s)	
	To 11 withii To 18 comp	Me	29b. Signature and title of certifier	,	-		290	. License	number	17			_	oth, Day, Year)	
•			•	/ . "	w D			D	JM	7 /	1	100	chy ?	2, 2005	
-			30. Name and address of person	who completed cau	se of death (Iter	m 23a) (Type,		her	U	(qn	(	chev	Sull	2, ras	
П	Sta Registr		31. Date filed (Month, Day, Year)	Est.	Registrar's Signa	ature	اور								

				Department of Health and M Certificate of Death	lental Hygie Reg.	600	35467
	Physicia	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Donald McNeil Harris  4a. Facility Name (If not institution, give street and number)	4h Cir. Tananalanailan (Danh	Nov.	1, 2005	
	Examin	ier	6418 Oakland Mills Road	4b. City, Town, or Location of Death  Synesville.		Carroll	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	thday) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye		hplace (State or Foreign
	Director		211 00 000	Yrs. Months Days Hours Min.	October 21,		untry)
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	n or Location			10d. Inside City Limits
	Maryl f sho	Ď		resuille			1 ☐ Yes 2 ☐ No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Co	untry?
	th wit	ai D	6418 Oakland Mills Road	21784		USA	
	tems	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
5	rs afte	by F	1 Mever Married 2 Married 1 Meyes 2 No If Yes, Give Year or Dates: 1978 1978 1978 1978 1978 1978 1978 1978	1 ☐ Yes 2 ☐ No Specify:		Specify: W	nite
ž	be filed within 72 hours after death with the Maryland lal Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Ener'li writinal ke buillied al	ted	15. Decedent's Education 16a.	Decedent's Usual Occupation	16b	. Kind of Business/	
<u>''</u>	ithin 7	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)			,
7	led wi	Con	12_	Laborer		rpentry	
מום	ntal Hed ot	Be	17. Father's Name (First, Middle, Last)  Denald McNeil Harris		(First, Middle, Maid		4
Ž	should nd Me mark matic	٦		. Mailing Address (Street and Number or Rura	y Lee	Langto	Zin Code)
M	alth a			418 Oakland mills Road	A.		
Ç.	es 1 a of Hea f item r othe			ne oromatone or other place)		Location - City or	
Saltimor	Pag ment tant: f		'4 © Conation 5 □ Other (Specify)  Ancoromy	Gifts Registry , Inc 11/	1 /05 H	anover, A	10
סמ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Michell Exar, it is it interest to indifficial and once.		21. Signature of Faneral Service Licensee	22. Name and Address of Facility Ana	tomy G. F. B. R. 184 Drive	STEP. In	,
	100		23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	encer			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of	of):			
		e	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of	of);			
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events c				
Ď,	e exectian an	Exa	resulting in death) Last Due to (or as a consequence of	of):			
00/0	icate be executed physician and s the burial-transit	dicai	d				
×	ding p	0	IF FEMALE: 23b Was decedent organist 23c. If yes, outcome of pregnancy				
DOX	The law requires that the death certifi ste has been signed by the attending page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of del Month	ivery Day Year
Ċ.	t the d by the ached	hysi	9 Unknown 9 Unknown				
, T	es tha gned	by P	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
	requir sen si nould	ted	Staph aureus intertion		1 Tes	2 <b>0</b> No 3□Pr	obably 4 Unknown
Records,	e law has b	Completed			24a. Was an autopsy	l pnorto o	topsy findings available completion of cause of
VIIAI	.0	e Co	05.10		performed	? death? No 1 ☐ Yes	2 No
	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1  Yes	26. Place of Death tpatient 3 DOA Other: 4 Nursing Hon	(Check only one) ne 5 Residence	a E 0 11 / 0	
ō	ding Physician: h. After this certific funeral director,	<b>—</b>	27. Manner of Death 28a. Date of Injury 28b. T	Time of 28c. Injury at 2	28d. Describe how in		city)
VISION	endin eath. or: Af	atio	2 Accident investigation	njury Work? M 1 Yes 2 No			
Š	or Att	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
_	spital ours a neral (	0	29a. Certifier Certifying Physician: To the best of my knowledge	death occurred at the time, date and place of	and due to the square	(a) and manner as	atata d
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera	fedical	one) and manner stated.	d/or investigation, in my opinion, death occurre	ed at the time, date a	and place, and due	to the cause(s)
	To To	Σ	29b. Signature and tolle of certifier  Com Cleratorfeel MS	29c. License number 0 2-4316		Date signed (Monti	
	44		30. Name and address of person who completed cause of death (Item 23a) (		ces Justin	rete at t	a Equan
	Sta	ite	31. Date filed (Month, Day, Year)  32. Resistar's Signature	in in much st of	rosel	1-19 2	25/
h	Registr	ar	NOV 0 3 2005	103 Frankler Ly D			

		1	For State Registrar	State of I	Maryland / De <i>C</i>	partment of Hea ertificate of De	ilth and Mer <i>ath</i>	ntal Hygie		35468
			Decedent's Name (First, Middle, Las	t)			2.	Date of Death	Day Year	3. Time of Death
	Physicia /Medic		Talisa A. Howl	ett					27 2005	10:45 P M
	Examin		4a. Facility Name (If not institution, give		er)	4b. City, Town, or Local	ation of Death		4c. County of Dear	th
			3434 Edmondson Av		Age (In yrs. last birthda	Baltimore		Date of Righ	O Rid	hplace (State or Foreign
	Funeral Director		5. Social Security Number 6. Social Security Number 1	M 2∭0 F /.	46 Yrs.		ours Min.	Date of Birth (Month, Day, Ye 7/07/195		ifornia
		-	Usual Residence of Decedent		40			//0//193	o car	
	nylan show	.	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits 1 ∑Yes 2 □ No
	Ba-1 s	Director	Maryland		Balti			10-	Citizen of What Co	
	with the		10e. Street and Number			10f. Zip Code				ountry ?
	eath ns 23	erai	3434 Edmondson Ave	12. Was Decede	ent Ever in U.S. 1	21229 3. Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Specify		U.S.A.	erican Indian,
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural; or Items 23a or 28a-f show or other traumatic event, the Medical Examinar minst be multiled at or other traumatic event, the Medical Examinar minst be multiled at	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force  1  Yes 2  If Yes, Give  Year or Date	<b>∑</b> No		lexican, Puerto Rici pecify:	an, etc.)	Specify: B1	
5-0036	tural stural	ed h	15. Decedent's Ed	lucation	16a. De	cedent's Usual Occupation		16b	. Kind of Business	/Industry
215	within 72 ene. then "ne he Medic	Completed	(Specify only highest gra	de completed) College (1-4	*life	ve kind of work done during b. DO NOT use retired)	g most of working			
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pu	2 should be filed within and Mental Hygiene. Is marked other than aumatic evant, the Mental aumatic evant, the Mental aumatic evant.	Be	17. Father's Name (First, Middle, Last)				Mother's Name (F			
yla	should be Ind Mental I	2	Keith G. Allen	Duna Dainel	105 14	ailing Address (Street and I	loria J.			Zin Codo)
Maryland	d 2 sh h and 7 is n traun		19a. Informant's Name/Relationship ( Keith G. Allen /			Poplar Grove				
	1 and Health Iem 27 other tr		20a. Method of Disposition	rathet	20b. Place of Di	sposition (Name of	Date	20c	. Location - City or	
nor	Pages nent of thant: If ite arry or of		1 Burial 2 Cremation 3 C		ate	rematory`or other place) norial Pk. Ce	11/12/2	2005 Ba	ltimore,	Maryland
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licer			22. Name and Address of 4611 Park Hgt	Facility The D			
			23a. Part1. Enter the disease, or com	plications that cau	ised the death. Do not				ore, mary	Approximate Interval Between
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each	anta to	RINO	1	mæ	1	Onset and Death
4	/Medical		disease or condition resulting in death)	Due to (or	as a consequence of):	00000	30 00	ucce		
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	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence of):					
	cate be executed oblysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequence of):					
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O. Box (	e death certifica the attending phaned for use as the	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Who 9 □ Unknown	1□Live birt	nt at time of death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of de Month	livery Day Year
۵.	hat th ad by I detach	Phy	Part II. Other significant conditions of	ontributing to dea	th but not resulting in th	e underlying cause given in	Part I.	23e. Did tobac	co use contribute t	o the cause of death?
of Vital Records,	w requires that the death been signed by the atte should be detached for	ed by						1 🗆 Yes	2 0 No 3□P	robably 4 DUnknown
Зесс	e la has	mpiet						24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
<u>a</u>		e Co	25. Was case referred to medical			26	5. Place of Death (C	1 Yes 2	No 1 ☐ Yes	3 2 □ No
₹		ToB	examiner?	Hospital:	patient 2 ER/Outpa	Othor	4 Nursing Home	1	e 6 □Other (Spe	ecify)
o	ding Phys h. After this funeral di	اقا	27. Winner of Death	28a. Date of (Month,		e of 28c. Injury at		I. Describe how i		
ior	Attanding r death. ector: After by the fune	atio	1 Vatural 5 Pending investigatio	n	,.		2 🗆 No			
Division	spital or Attan ours after deat leral Director: filled in by the	Certification:	3 Suicide 6 Could not be determined	286. Place o	f Injury - At home, farm g, etc. (Specify)	street, factory, office	28f	Location (Stree City or Town, S		ural Route Number,
	To the Hospital or Attanowithin 24 hours after death To the Funeral Director:	edical C			is of examination and/o	eath occurred at the time, or r investigation, in my opinio				
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	1		29c. License nu	ımber	29d.	Date signed (Mon	th, Day, Year)
	/ /		texter.	· / Ce	un	736	146	11	-1-20	205
E.			30. Name and address of person who	1	of death (Item 23a) (Ty	pe, Print)	7 C G20	eus S	+ Rn1	fin - Mi
	Sta	ate	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signature	l will	SUR	eur -	, sac	1 Course
	Regist	rar	NOV 0 3 2	2005	Care St 1	Signal of				

State of Maryland / Department of Health and Mental Hygiepen 05 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician Bartholomeus Herbert, Jr. 6:50 a October 27, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Ellicott City Howard 2633 Golf Island Road If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 1 ☐ M 2 ☐ F Yrs. 50 Director 529-74-5678 October 7, 1955 **Utah** Usual Residence of Decedent e filed within 72 hours after death with the Maryland it Hygiene. other than "naturel", or iteme 23a or 28s-1 ehow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "naturel", or iteme 23a or 28a-f ehow the Medical Examinational be notified at 1 ☐ Yes 2√☐ No Director Ellicott City Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21042 2633 Golf Island Rd Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 | Yes 2 | No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Self-Employed Elementary/Secondary (0-12) College (1-4or 5+) Founder 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Pages 1 and 2 should be fill timent of Health and Mental H tant: If Item 27 is marked oth jury or other traumatic even Be Everdina t'Hart Bartholomeus Herbert 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2633 Golf Island Rd. Ellicott City, Maryland 21042 Ms. Janet Herbert 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If eny injury or once. 10/31/2005 Marriottsville, Maryland Crest Lawn Memorial Gardens 21. Signatur y Funeral & rvice Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. MOOS Cuntilly. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** lioblastoma mul years /Medical Doe to (or as a consequence of): Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 🗆 Yes 2 No 1 Yes Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After the 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D35254 10-28-05 ss of person who completed cause of death (Item 23a) (Type, Print) 900 Catonave a role Miller 32. Refistrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 3 2005 Registrar

Aı	ndrea J	loh:	nson 1- <sup>For</sup> State Registrar	State of	Marylan		artment			Mental H	ygien Rag. N	711115	35470
			1. Decedent's Name (First, Middle	a, Last)						2. Date of I	Death Da	ay Year	3. Time of Death
	Physici /Medio		Lena		Joh	nson				Octobe		-	10: 53P <sup>M</sup>
	Examir		4a. Facility Name (If not institution	n, give street and numb	oer)		4b. City, 7	Town, or L	ocation of De	ath	4	c. County of Deat	
	4 -		Northbound I-296		A // /	to a A to take the late	Be1	tsvil	le la la la la la la la la la la la la la	TO 10 0 15	Pı	cince Ge	orge's
Н	Funeral		5. Social Security Number 580-11-7191	6. Sex 7.	Age (In yrs. I	as <i>t birthd</i> ay) Yrs.	If Under Months	Days	Hours Mi	n. (Month, L	Day, Year	9. Birt	hplace (State or Foreign untry)
5	Director		Usual Residence of Decedent							October	22,	1975   Guya	ina
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
	a-f s	ctor	Maryland Prince	Georges	Upper	Mar1bo	ro						1 ☑ Yes 2 ☐ No
	or 28	Director	10e. Street and Number				10f. Zip				10g. C	itizen of What Co	ountry?
	ath w		4409 LT. Landsdale			0 1	207					ed States	
(0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23a or 28a-f show any highty or other traumatic event, if a Medical Exam as must be notified at ODE.	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☑ Marr	12. Was Deceded Armed Force 1 Tyes 2	es? ∏No			~		(Specify Yes or Nerto Rican, etc.)	10-	14. Race - Ame Black, White	e, etc.
ğ	rel', c	1 by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date			1□Yes 2	No No	Specify:			Specify: Bla	ick
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р П	Hygie ther ther		17. Father's Name (First, Middle,			Filysic	al The			ame (First, Midd			
lan	Mental Mental rked o	To Be	Allan B. Johnson						Irma Gi	ttens			
Maryland 21215-0036	2 should and he ls ma	0 1	19a. Informant's Name/Relations				-					or Town, State, Z	Zip Code)
e)	1 and Health am 27 ther to		Allan B. Johnson/F	ather	20h. P	8411 Clace of Dispo			ive Lat	urel, Mar Date		20708 Location - City or	Town State
altimore,	ages ant of I at: If its		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		ate ce	emetery, crer ge Wash	natory or ot	her place)	1	/2005		phi Maryla	
≡ a	partm porter y injur		21. Signature of Funeral Service			22	2. Name and	d Address	of Facility	Fleck Fune	ral H	ome	
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8760, <	Physician and /Medical Examiner into pural-transit into pural-transit	ilcai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, I arry lead by the minimal attacts. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	as a consequence as a c	uence of):	ries						Onset and Death
O. Box 6	Attending Physician: The law requires that the death certificate be executed rideath.  •ctor: Atter this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 15€ Inknown		h 2 ⊟ Fetal nt at time of de	death 3	Ectopic pre					23d. Date of deli Month	ivery Day Year
S, P	ires that signed t d be det	þ	Part II. Dther significant condition	ons contributing to dea	th but not resu	ulting in the u	nderlying ca	ause given	in Part I.				the cause of death?
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Division of Vital	rician: Th certificete rector, pag	Be (	25. Was case referred to medica examiner?					1		eath (Check only	one)		
=	Physic this c	မ	1 ☐ Yes 2 ☐ No	Hospital: 1 🗆 Ing		ER/Outpatier			4   Nursing			6 ₩Other (Spec	Scene
Z Z	After After funer	Certification:	27. Manner of Death 1 □Natural 5 □ Pendir	LU .	Day Year)	28b. Time or Injury	28	Bc. Injury a Work?		28d. Describe	e how inju		rehicle
S	death death ctor: y the	Ical	2 Accident investi 3 Suicide 6 Could	not be and Blace o	9-05   f Injury - At ho	me tarm str	eet tactory		s 2 No	Javal	ed	in collis	ral Route Number.
<u>S</u>	efter efter Dire	ert	4 Homicide determ	building	, etc. (Specify	")	بالح	, 5.11.00		Gity or T	own, Star	e)	-295
	To the Hospital or Attending Physician: The within 24 hours eiter death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page		29a. Certifier 1 Certifyir (Check only 2 XMedical	ng Physician: To the b Examiner: On the bas	est of my know	wledge, deatl	n occurred a	at the time	, date and pla	ce, and due to th	e cause(	s) and manner as	stated.
	the hin 24 the F	Medical	one)	and manne	r stated.					ourrou at trie (IM)			
	100 CO	-	29b. Signature and title of certifie	0	$\cap$			License r	number			ate signed (Monti	
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	Physici		1. Decedent's Name (First, Middle, La Alice Jeanette								2. Date of Domestin OCTOBE	Da	ž <sup>y</sup> 2ď	ear 05	3. Time of Death	M
	/Medic Examir		4a. Facility Name (If not institution, gir		ımber)				Location		001022	40	c. County of	Death	0.00	
	Funeral Director			UE Sex 1□M 2只F	7. Age ( <i>in yr</i> s	. last birthday) Yrs.		r 1 Year Days	If Under Hours	Min,	8. Date of Bi (Month, D	rth ay, Year,	) 9	. Birthpi	lace (State or Foreig try)	
	/land		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	cation								Od. Inside City Limit	
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	and I	10	13103 Sixth Aven	110			10f, Zip	Code	01500			10g. Ci	itizen of Wh	at Coun	itry?	
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21215-0036	ithin 72 ho le. lan "natur Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ade completed)	1-4or 5+)	16a. Dece (Give life.	dent's Usu kind of wo DO NOT u	rk done o	turing mos	st of workii	ng	16b. K	(ind of Busin	ness/Ind	dustry	
and 21	I be filed wintal Hygien ed other the event, the	Be	12 17. Father's Name (First, Middle, Las Charles Wade S				post	al c		er's Name	(First, Middle			l sy	ystem	
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Baltimore,	permit. Page Department of Important: if any injury or once.		21. Signature of Europeal Service Lice		irecto		Namear ate 1	Anato	omy B	ty oard 21201	655 W.	Bal	ltimor	e S	treet	
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	/Medical Examiner		resulting in death)	- PHP	onte ou	True t	ive p	ulmo	nary	dise	ase				yrs	
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68760,	cate be executed physician and the burial-transit	dical Exa	resulting in death) Last	Due to	(or as a conse	quence of):										
P.O. Box 68	The law requires that the death certifica ate has been signed by the attending pl page 2 should be detached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 25 No 9 □ Unknown	1 ☐ Live I	itcome of pregn birth 2 Fet nant at time of d	al death 3	Ectopic pi						23d. Date o Month		ry Day Year	
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of Vital Records,		Completed					-				24a. Was auto perfo		prio dea	r to com	psy findings available pletion of cause of 2 No	е
Vita	Physiclan: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only		1			_
on of	ding After fune	tlon: To	Yes 2 No  27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date (Mor		28b. Time of Injury		28c. Injury Work	4 🗆 NU	2	8d. Describe			Specify	)	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not to determined	28e. Place	e of Injury - At hing, etc. (Speci	nome, farm, str	eet, factor	y, office		2	Bf. Location ( City or To			or Rural	Route Number,	
	To the Hospital or within 24 hours after To the Funeral Director completely filled in	Medical	29a. Certifier (Check only one)	miner: On the b	e best of my kn pasis of examination of stated.	owledge, death ation and/or in	occurred vestigation	at the tim	e, date an inion, dea	d place, a th occurre	nd due to the d at the time,	cause(s)	) and manne d place, and	er as sta	ated. the cause(s)	
)	To th withir To th comp	Me	29b. Signature and title of certifier	/~~	Dpty M	led Ex		D091			(		te signed (A	fonth, E		
			30. Name and address of person who PAUL SNOW, M.D.	completed cau				ERT.A1	ND,MD	2150	)2					_
	Sta Registr		31. Date filed (Month, Day, Year)	32 F	Registrar's Sign		AGE P									_

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Examiner				_	or Location of Death	1	4c. County of De	
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72 hours after death with the Maryland natural; or items 23e or 28e-f show licel Frank or must be notified at	10a. State 10b. Co	altimore	10c. City, Town o					10d. Inside City Lir 1 Yes 2
or 28	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?
23a 23a	603 Gouche	r Blvd.		212	286		USA	
iams iams	11. Marital Status	Armed Ford	dent Ever in U.S. ces?	<ol> <li>Was Decedent of F If Yes, specify Cub</li> </ol>	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Arr Black, Wh	
ural, or it	3 Widowed 4 □ Divo	orced If Yes, Give Year or Da	tes:	1 ☐ Yes 2 🖁 No			Specify:	white
s 1 and 2 should be lied within 72 hours after death with the marylan fleshift and Memberl Hygiene. If Health and Memberl Hygiene. Other traumatic event, I'm Medical Eranicar must be notified at other traumatic event. I'm Medical Eranicar must be notified at To Be Completed by Funeral Director	15. Dec (Specify only h Elementary/Secondary (0-		4or 5+)	ecedent's Usual Occup live kind of work done fe. DO NOT use retire	during most of world)	king	16b. Kind of Busines	,
Hygie Ther Int.		n/a		Homemake	1	ne (First, Middle,	Own Hom Maiden Surname)	e
To Should be flight within and Mental Hygiene 7 is marked other then "raumatic event, trained To Be Comple		nian	10h A	lailing Address (Ctrast	Rosa	Kazanjia	•	Zin Codal
ulth and 27 is n r traur	Kirkor Kazaz			Barranco				Zip Code)
ages I and of Healt if Item 2		tion 3 □Removal from S	20b. Place of D cemetery,	isposition (Name of crematory or other pla	ce) 11,	Date /5 / 05	20c. Location - City of	
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Depa impo eny ir	Michael J 23a. Part Enter the disease	Flagle		TO W. Pa	donia Kd	., i imor	num, MD	21093
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engi e	Part II, Other significant co	nditions contributing to dea	ath bul not resulting in the	ne underlying cause gr	ven in Part I.	23e. Did to	obacco use contribute	to the cause of deat Probably 4 Unk
has b						24a. Was a autop perfor	sv prior to	aulopsy findings ava completion of caus
certificate rector, pag	25. Was case referred to me	edical				th (Check only or	ne)	
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after death. Director: After in by the fune	27. Manner of Death  1	vestigation ould not be	f Injury o, Day Year) 28b. Tin Inju	13 M 10	nyat rk? ]Yes 2. ∑ENO	28f. Location (S City or Tow	By A.C. Street and Number or I	
thin 24 hours in the Funeral ampletely filled		rtifying Physician: To the ladical Examiner: On the ba	sis of examination and/	leath occurred at the tropr investigation, in my	me, date and place opinion, death occu	and due to the	cause(s) and manner a date and place, and di	
within 2 To the comple	29b. Signature and title of c	entition		29c. Licen:	se number		29d. Date signed (Mor	nth, Day, Year)
	<b>*</b> * * * * * * * * * * * * * * * * * *	11	>	0.C.1	м.Е.	N	lovember 02	2, 2005
5	MAY	ersort who completed cause	PUSmy 1	ll Penn Sti	reet, Bal	timore,	Maryland 2	1201
State Registrar		79ar)1 32. Re	egistrar's Signature	del				

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 1,<sup>Day</sup>005 **Physician** NOV. FRANK KOCYAN 12:15 a<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FUTURE CARE CANTON HARBOR BALTIMORE N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign SEPT 24, 1934 MARYLAND **Funeral** Months Days Hours Min. 1XM 2□F 71 215-30-9824 Yrs. Director Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23e or 28a-f show treumatic event. It a Madical Experiment is ust be notified at 1 Yes 2 □ No Director MD. N/ABALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3601 HUDSON STREET 21224 U.S.A. Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married Married Specify: WHITE 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene ont: If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 ELECTRICIAN SELF\_EMPLOYED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FRANK J. KOCYAN, SR. THERESA DOBRZYKOWSKI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21224 19a. Informant's Name/Relationship (Type, Print) DOROTHY KOCYAN/ WIFE 3601 HUDSON STREET, BALTIMORE, MARYLAND other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department c Importent: If ŏ SACRED HEART OF JESUS 11/4/05 BALTIMORE, MD. 4 ☐ Donation 5 ☐ Other (Specify) injury 21. Signature of Funeral Service Licensee LILLY & ZEILER ZILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTO., MD. 2 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a ch line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Wetastahi **Physician** rostrate /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): the attending physician by Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 23e. Did tobacco use contribute to the cause of death? pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? certificate 1 Yes 2 1 10 or Attending Physicien; filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and manhar stated. 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Nurie and andress of person who completed cause of death (Item 23a) (Type, Print) Rich 280 Jonat 00 31. Date Med (Month, Day, Year) 32. Registrar's Signature State NOV 0 3

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15

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	· Physici		1. Decedent's Nam-		, Last) KULBI (	CKT						2. N(	Date of De De DV . 2	eath 2 . 2 C	<sup>y</sup> 0.5	Year	3. Time of 1:10	
	/Medic Examin		4a. Facility Name (						4b. City,	Town, c	or Location of				. County of	f Death		
			JOSEPH	RICHE	Y HOSI	PICE					IMORE				N/	A		
	Funeral Director		5. Social Security N 213-16-4	1180	6. Sex 1 ☐ M 2			3 Yrs.	If Under Months	1 Year Days		Min. MZ	Date of Bir (Month, Da AY 18	th ay, Year 3, 19	22	9. Birthp Cour MAF	place (State of http:// XYLANI	r Foreign
	land w		Usual Residence of 10a. State	10b. County			10c. Cit	y, Town or L	ocation								0d. Inside Ci	ty Limits
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	th the Marylan or 28a-f show	lrec	10e. Street and Nu	mber					10f. Zip	Code				10g. C	itizen of Wh	nat Cour	ntry?	
	ath wi	ral	152 N.	LAKEW							1224				U.S.			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Inportant of Heatlib and Mental Hygiene. Inportant: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantral must be neithfield and once.	by Funeral Director	11. Marital Status 1 ☐ Never Marr 3 ☑ Widowed	_	ied 1	s Decedent ned Forces? Yes 2 <b>X</b> es, Give ar or Dates:		S. 13.			Hispanic Orig an, Mexican, Specify:	gin? (Specif , Puerto Ric	y Yes or No an, etc.)	)- 		- Amend , White,		
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Maryland 21215-0036	ithin 7 ne. nen "r	Completed	Elementary/Seco	. , ,		llege (1-4or 5	5+)	life.	DO NOT us	e retire	ed)	or working		OT C	ארווו אי		RETAII	_
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and	ld be lental l	To Be	STANISI		TRZCII	NSKI						ONIC			CZAK	,		
/ <u>S</u>	shouland Mandamari	-	19a. Informant's N		hip <i>(Type, Prir</i>	nt)		19b. Mail	ng Address	(Street	t and Number	r or Rural R	loute Numb	er, City	or Town, S	tate, Zip	Code)	
Z	and 2 salth a n 27 ii		CAROLYN		CKI/D	AUGHT					WOOD						21224	4
1/2/6Saltimore,	Pages 1 ment of He ant: If iter ury or oth		20a. Method of Dis XXBurial 2 '4 Donation	Cremation	3 □Remova oecify)	I from State	20b. P	lace of Disp emetery, cre STA	matory or o	ther pla	CEM.	11/			ocation · C	•		LAND
Balt	permit. Departi		21. Signature of Fu	Ineral and ice t	Licensee	the		L 1	Z Name an ILLY 901 I	Addre	ZEILE TERN	R INC	C. FU UE,BA	JNEF LTI	RAL H	HOME MI	2 2. 212	231
			23a. Part1. Enter t shock, or hea Immediate Cause	art failure. List	complications only one caus	se on each li	ne.		1			4 -4	espiratory a	rrest,			Approximate Interval Bette Onset and I	ween Death
	Physician /Medical		disease or condition resulting in death)	on	a	Oue to (or as		o Yo√a uence of):	Scall	a.v	acci	clem				- X	Week	5
	Examiner		O LIKE BURGE	on Weeks														
٤.,	sit	iner	if any, leading to in cause. Enter Under Cause (Disease or	nmediate erlying		Due to (or as	a conseq	uence of):										
FA.	tificate be executed g physician and as the burial-transit	Examiner	that initiated events resulting in death)	S	c.	Due to (or as	a conseq	uence of):	_					_		-		
0:1	e be e				d													
- 89	tificati ng phy as the	Medical	15 55444 5													ļ		
	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/N	IF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknown	months?	1 4	es, outcome ]Live birth ]Pregnant at ]Unknown	2 Feta	Ideath 3	⊒Ectopic pr ⊒ Other (sp		ey .				23d. Date Mont		-	/ear
_ a	es that tigned by	by Ph	Part II. Other signi	ficant condition	ns contribution	ng to death b	out not res	ulting in the i	inderlying c	ause giv	ven in Part I.		23e. Did t	tobacco	use contrib	oute to t	ne cause of d	eath?
KULB	quires an sign												10	Yes 2	.□ No 3	☐ Prob	ably 4	Inknown
	law re as be	Completed											24a. Was		24b. We	ere auto	psy findings mpletion of c	available ause of
7 4	The cate h	Con												ormed?		ath? ] Yes	mpletion of c	
<b>├</b> \$	Physician: The Ithis certificate har	Be	25. Was case reference examiner?	_	Hospital	 l:		<del></del>		Ott	hon	of Death (C					1	Sec. 20
A P	Phys or this sral di	. To	1 ☐ Yes 2 ☐ 27. Manner of Dea			1 ☐ Inpatie Date of Inju (Month, Da		ER/Outpatie		8c. Inju Wo	4 🗀 Nur	rsing Home	5 ∐ Resi d. Describe		6 Other iry occurred		mesp	1CB
# 0	Attending Frideat. sctor: After by the funer	attor	1 Natural 2 Accident	5 Pending investig	9	(Month, Da	y Year)	Injury	м		ork? ]Yes 2 🗋 N	No						
MAKGINET KULB Division of Vital Records.	To the Hospital o. Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 🗌 Suicide 4 🗍 Homicide	6 Could r determi		. Place of Inj building, et	ury - At ho c. <i>(Specil</i>	ome, farm, st	reet, factory	, office		28f	. Location ( City or To			or Rura	al Route Num	ber,
8	ne Hospil n 24 hour ne Funera aletely fille	edical (	29a. Certifier (Check only one)	1 Certifyin 2 Medical I	g Physician. Examiner: Or an	To the best in the basis o id manner st	f examina	wiedge, dea tion and/or in	n occurred ivestigation	in my	ime, date and opinion, deatl	place, and h occurred	at the time,	cause(s date an	) and man d place, an	ner as s id due to	the cause(s	)
	To the I	M	29b. Signature and	title of certifier	r				290	_	se number	63		29d. Da	ite signed	(Month,	Day, Year)	
	0		1 4	USD MI	)					V	2417			Nov	embe	1 2	2, 200	5
	1		30. Name and add	ress of person	ho complete	ed cause of c	leath (Item	23a) (Type	Print)	54	7	with 1	LOVO	M	D 21	7 1	i	
	Sta	ate	31. Date filed (Mor	nth, Day, Year)	7 170	32. Registr	ar's Signa	iture A	Macro			70017	, , ,	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		20		
	Registr	iar	l	0 0 1	MADE !	Wa.	Red	No.	200 13									

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	•	ertificate of Death	nentai mygier Reg. i	/1100 304/0	į
	Physici	an	Decedent's Name (First, Middle, Last,		77 - * + 1	2. Date of Death Month	3. Time of Death 30, 2005 3:17PM	
5	/Medic	al	Raymond  4a. Facility Name (If not institution, give	Eugene	Keith  4b. City, Town, or Location of Death		30, 2005   3:17PM   4c. County of Death	_
	Examin	ier	7904 Oxon Hill R		Oxon Hill		Prince George's	
	Funeral Director		5. Social Security Number 6. Set 300-22-5700	7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda	ly If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yes	9. Birthplace (State or Foreig Country) West Virginia	חן
	yland yland		10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limit	
	8a-1 e	ctor	Maryland Prince G	eorge's	Oxon Hill		1 ☐ Yes 2 ☐ N	٥
	eth with the 23a or 2	ral Dire	10e. Street and Number 7904 Oxon Hill Ro		10f. Zip Code 20745	U	Citizen of What Country?	
Maryland 21215-0036	permit. Pages t and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "natural", or iteme 23a or 28a-f ehow with highty or other treumatic event, the Modical Examinant must be publified at ODGs.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S.     Amyed Forces?     1	<ol> <li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:</li> </ol>	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White	
5	n 72 h natu	lete	15. Decedent's Edu (Specify only highest grad	cation 16a. De (G.	cedent's Usual Occupation ve kind of work done during most of work b. DO NOT use retired)	ing 16b.	. Kind of Business/Industry	
212	d withi	mo:	Elementary/Secondary (0-12) 12th	College (1-4or 5+)	eral Police		S. Military	
bu	be file tal Hyg d othe	Be	17. Father's Name (First, Middle, Last)			e (First, Middle, Maid		
<u> </u>	d Men marke	၉	Raymond S. Keith  19a. Informant's Name/Relationship (T)		DOT OT	thy M. Coo		_
Ma	alth an 27 le		Maria Keith (Wife		4 Oxon Hill Road Ox			
Baltimore,	Pages t a nent of He int: If item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State 20b. Place of Discometery, of Lee Cre	rematory or other place) $N_{ m OV}$ .	2,	Location - City or Town, State	
Balti	permit. Departn Imports eny Inju		21. Signature of Fune al Sirver Library	+/ ,	22. Name and Address of Facility $Le\epsilon$	Funeral		35
			shock, or heart failure. List only or	ications that caused the death. Do not one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	er, metastati	<u> </u>	1 year	
	Examiner			Due to (b) ag a consequence on).				
	sit sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of).				
	axecution and al-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):				
68760,	tificate be executed to physician and as the burial-transit	edical		d				
		- T	IF FEMALE:	23c. If yes, outcome of pregnancy				
P.O. Box	The law requires that the death cer are has been signed by the attendir page 2 should be deteched for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1☐Live birth 2☐Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery  Month Day Year	
	en signed bould be det	۵	Part II. Other significant conditions con	ntributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death? 2 No 3 Probably 4 Minknow	n
Vital Records,	The lay ate has page 2	Completed				24a. Was an autopsy performed		Θ
Z Eta	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	Others	h (Check only one)		
o	Attending Physician: r death. sctor: After this certification the funeral director, it	n; To	27. Manper of Death	1 ☐ Inpatient 2 ☐ ER/Outpat  28a. Date of Injury (Month, Day Year)  28b. Time Injur	of 28c. Injury at	28d. Describe how in	6 □Other (Specify)	
sior	eath. or: Aft the fur	catlo	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Your)	M 1 Yes 2 No			
Division	Hospital or Att 4 hours efter d Funeral Direct tely filled in by	Certification;	4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)		City or Town, St		
	To the Hospital or Attent within 24 hours efter deatl To the Funeral Director: completely filled in by the	Medical	one)	sician: To the best of my knowledge, de ner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	red at the time, date a	and place, and due to the cause(s)	
•	To To	2	29b. Signature and title of certifier	ymo Physicia	29c. License number  DS3590		Date signed (Month, Day, Year)  VEMBER 2, 2005	
•	1			A				-
1	$\prec$		30. Name and address of person who co	1200M 609	BALTIMO!	SAPWAY LE MO	21205	

05-7303 AKG	State of Maryland / Department of Health and Mental Hygiene
AKG	1- For Unpend Item 23a-b&27 per me 6849 11-22-05 tas Certificate of Death Registrar
安克 作家人	1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death
Physician /Medica	
Examine	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
	Johns Hopkins Bayview Hospital Baltimore
Funeral	5. Social Security Number 6. Sex 1 Months Days Hours Min. 6. Sex 1 Months Days Hours Min. 9. Birthplace (State or Foreign Country) 9. Birthplace (State or Foreign Country) 4 Months Days Hours Min. 1 Months Days Hours Min. 2 Months Days Hours Min. 2 Months Days Hours Min. 2 Months Days Hours Min. 2 Months Days Hours Min. 2 Months Days Hours Min. 2 Months Days Hours Min. 2 Months Days Hours Min. 2 Months Days Hours Min. 2 Months Days Hours Min. 2 Months Days Hours Min. 2 Months Days Hours Min.
Director	Usual Residence of Decedent
. 0	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
vith the Mar t or 28s-f et	MD Baltimore 150 2 No
or 28	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
ath w	4805 Bayonne Ave. Apt ( 21206 USA
6 after death w after death w	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
Urs aft	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify: Specify: Specify: Specify: Specify:
und 21215-0036  be filled within 72 hours after death with the Maryland tiat Hygiene. Indicate than "natural", or iteme 23a or 28a-1 show event, the Madical Exempler must be notified at Re-Completed by Eumeral Director	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
21215-00 ed within 72 ho ygiene. ser than 'naturi	(Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)
d 212 d 212 filed with hygiene. sut, the	
be fill be out	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)  Devron D. Loycett S.R.  Suzette Moure
Maryland d 2 should be file th and Mental Hy tr Is marked oth treumatic event	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
, Ma and 2 s ealth an m 27 ts	Carolyn Hard 1003 E. Coldspring LN. Balto. MD 21212
ore, M ss 1 and 2 of Health iltem 27 I	20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State
imor Pages nent of h ant: If Ite	1) Seurial 2   Cremation 3   Removal from State 4   Donation 5   Other (Specify)  New Cothedral   11/4/05   Baltimore, MD
Baltimore, permit. Pages 1 at Department of Hea Important: If the any Injury or othe once.	21. Signature of Funeral Service Licensee
<b>o</b> 88 <b>s</b> 8	lun W. Sun 4905 York Road, Beste. MD 21212
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between
Physician	Immediate Cause (Final disease or condition and Death disease or condition are within and Death disease or condition and Death disease or condition are within and Death disease or condition and Death disease or condition are within a disease or condition and Death disease or condition are within a disease or condition and Death disease or condition are within a disease or condition and Death disease or condition are within a disease or condition and Death disease or condition are within a disease or condition and Death disease or condition are within a disease or condition and Death disease or condition are within a disease or condition and Death disease or condition are within a disease or condition and Death disease or condition are within a disease or condition and Death disease or condition are within a disease or condition and Death disease or condition are within a disease or condition and Death disease or condition are within a disease or condition and Death disease or condition are within a disease or condition are within a disease or condition and Death disease or condition are within a disease or condition are within a disease or condition and Death disease or condition are within a disease or condition and Death disease or condition are within a disease or condition and Death disease or condition are within a disease or condition and Death disease or condition are within a disease or condition and Death disease or condition are within a disease or condition and Death disease or condition are within a disease or condition and Death disease or condition are within a disease or condition are within a disease or condition are within a disease or condition are within a disease or condition and Death disease or condition are within a disease or condition are within a disease or condition and Death disease or condition are within a disease or condition and Death disease or condition are within a disease or condition and Death disease or condition are within a disease or condition and Death disease or condit
/Medical Examiner	resulting in death)  Due to (or as a consequence of):
* 105 %	Sequentially list conditions of any, leading to immediate cause. Enter Underlying  b. Endocardial Fibroelastosis  Due to (or as a consequence or):
executed in and in-transit	cause. Enter Underlying Cause (Disease or injury that initiated events  C.
760, te be executed ysician and te burial-transit	resulting in death) Last Due to (or as a consequence of):
P.O. Box 68' nat the death certificat dby the attending phy etached for use as the Physician/Media	IF FEMALE:
P.O. Box nat the death cert d by the attendin fetached for use i	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Year
O. I he de the a	1  Yes 2 No 9 Unknown 9 Unknown
that the de ded by the a detached if	
cords, wrequires the been signed by the bear signed by the bear be	
al Record  The law requir cate has been s page 2 should	24a. Was an 24b. Were autopsy findings available
of Vital Rehysicien: The land his certificate had director, page 2	24a. Was an autopsy findings available autopsy performed?  The performed are also as a completion of cause of a large are also as a completion of cause
/ital	
Of V Physic this ce al dire	1X Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
On C ding P L. After t funera	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Work? 28b. Time of 28c. Injury at Work?
/iSic Attend death releath retor: ,	2 Accident Investigation  3 Suicide 6 Could not be
Division of Vital Records, tal or Attending Physician: The law requires the staff death.  Sal Director: After this certificate has been signed in by the funeral director, page 2 should be completed by	286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  287. Location (Street and Number or Rural Route Number, City or Town, State)
2 5 € 9 C	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
the Hospi in 24 hou in 24 hou in 24 hou in 24 hou pletely filk	one)  (Client unity one)  2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
To the vithin 2 To the complet	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	0.C.M.E. October 30, 2005
INC P	30. Name and address of person who completed ∠use of death (Item 23a) (Type, Print)
V.	31. Date filed (Month, Day, Year) &32. Registrar's Signature
State Registrar	A COUNTY OF THE PARTY OF THE PA
	1400

		1 - For Registrar	State of Marylar	nd / Depa <i>Ce</i> a	artment o	f Health a	and Ment	al Hygie Reg.		35477
Physic /Medi		1. Decedent's Name (First, Middle, Last) RICHARD HEAPHY					Nov	onth ember	<sup>Day</sup> 2005	2:30A M
Exami	ner	4a. Facility Name (If not institution, give s 5906 Meadowood Road 5. Social Security Number 6. Sex		loot high dow		n, or Location timore ear   If Under		to of Righ	4c. County of E	Α
Funeral Director			7. Age (In yrs. 81	Yrs.		ays Hours	Min. Octo	of Birth Conth, Day, Ye Ober 8,1	924 Ma	Birthplace (State or Foreign Country) LYYLAND
death with the Maryland ms 23a or 28s-f show rmust be notified at	ector	10a. State 10b. County  Maryland N/A		ty, Town or Lo Caltimore	<u>,</u>				0	10d. Inside City Limits  Yes 2 No
3a or 3	DI	10e. Street and Number 5906 Meadowood Road			10f. Zip Cod 21212			10g.	Citizen of What	Country?
Z1Z15-UU30 d within 72 hours after death with the Marylan giene rithan "natural", or items 23a or 28s-f show the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married XX Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Amed Forces? XXI Yes 2 ☐ NoWIII If Yes, Give Year or Dates:		Was Decedent If Yes, specify (		igin? (Specify Y n, Puerto Rican,	es or No- etc.)		Merican Indian, White, etc. White
d Z1Z15-UU36 filed within 72 hours after Hygiene. ther than "natural; or the int, the Medical Examina	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Or kind of work d DO NOT use re	one durina mos	st of working		o. Kind of Busine Private Pr	
E Bigg	To Be C	17. Father's Name (First, Middle, Last) Charles Sebastian Lerch					er's Name <i>(First</i> guerite Mu		den Sumame)	
and 2 sho salth and n 27 is m		19a. Informant's Name/Relationship (Type Marie Logan Lerch	оө, Print) Wife		_		er or Rural Rout Itimore, N		ity or Town, Stai   21212	e, Zip Code)
o Figure		20a. Method of Disposition  **MS Burial 2			osition (Name of matory or other Cemetery		Date 11/5/05		altimore,	
Baltimo permit. Page Department o Important: If any injury or		21 Fignature of Funeral Service License	Kenakis	) 22	2. Name and A					al Home Inc ryland 21212
by Course are be executed white burial-transit the	lical Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	quence of):					ONOU E	Interval Between Onset and Death WEEKS
.C. GOX OS/ the death certificate by the attending phys ached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o	al death 3	Ectopic pregn Other (specif				23d. Date of Month	delivery Day Year
ecords, F.C. law requires that the de a: been signed by the 2 should be detached	þ	Part II. Other significant conditions con				•	. 2	_		e to the cause of death?  ] Probably 4 □Unknown
The language 2	Completed	CHRONIC CO	UGESTHE HEA	mr F.	ALURA			4a. Was an autopsy performed Yes 28	j? prior	
OT VITAL Physician: r this certifica	o Be	25. Was case referred to medical examiner?	ospital:			Cthor	of Death (Che			
c g eff	⊢	1 ☐ Yes 2 € No   27. Manner of Death  1 ② Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c.	Injury at Work?	28d. D		e 6 Other (S	Бресіfy)
DIVISION  To the Hospital or Attanding F within 24 hours after death. To the Funaral Director: After completely filled in by the funer.	Certification:	3 Surcide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str fy)	reet, factory, of	fice		ecation (Stree ty or Town, S		r Rural Route Number,
ne Hospif 24 hour 10 Funare	edical (	29a. Certifier 1 Certifying Phys (Cneck only one)	ician: To the best of my knower: On the basis of examination and manner stated.	owledge, deat ation and/or in	h occurred at the vestigation, in r	ne time, date ar my opinion, dea	nd place, and du ath occurred at t	e to the caus he time, date	e(s) and manne and place, and	r as stated. due to the cause(s)
To the within To the comp	Me	29b. Signature and title of certifier	Im MO		29c. Lie	cense number		29d.	Date signed (M	onth, Day, Year)
10		30. Pame and address of person who co	mpleted cause of death (Ite	m 23a) (Type, CHANIZ	Print) #	200 BA	TANCE	MD 21	204	
St Regist	ate trar	31. Date filed (Month, Day, Year)	32. Registrar's Sign.	ature	and I					

State of Maryland / Department of Health and Mental Hygiene 15 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day **Physician** October 26, 2005 p M Liebrecht 4:25 Finney: /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8687 Doves Fly Way Laurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, April 18, 9. Birthplace (State or Foreign Country) Pennsy I van i a 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M X F Days Hours 578-62-7016 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Items 23a or 28a-f ehow the Modical Examinar must be notified at Maryland Howard 1 Yes 2 □ No Laurel Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8687 Doves Fly Way 20723 United States America 12. Was Decedent Ever in U.S. Agned Forces? 1 ∰ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married White 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: δ 3 → Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Librarian Education permit. Pages 1 and 2 should be filed w Depertment of Health and Mental Hygier Important: If Item 27 Is marked other the eny injury or other traumatic event, ILL ODG. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Earl Finney Georgiana Finney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrea Creeden/Daughter 8679 Doves Fly Way Laurel, Maryland 20723 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Crownsville Veterans Cem. 10/31/2005 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign to re of turn gal Service Licensee 22. Name and Address of Facility 7601 Sandy Spring Road Laurel, Maryland 20707 Approximate Interval Between Onset and Death 23a. Part1. Éduc the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Melanomas **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it is a sequentially list conditions, and cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ettending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 sl autopsy performed? 1□ Yes 2 X No Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) 1 ☐ Yes 2 🖔 No 1 Inpatient 2 ER/Outpatient 3□ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 10/31/2005 D38409 n 30. Name and address of person who William H. Sharfman, hydo cause of death (Item 23a) (Type, Print). 10753 Falls Road, Pavillion II Suite 415 Lutherville, Maryland 31. Date filed (Month, Day, Year) Pegistrar's Signature State NOVO 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene [] [] 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year РМ OCTOBER 30 LEYDERMAN 2005 3:25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5715 PARK HEIGHTS AVENUE APT. #406 BALTIMORE N/A Date of Birth SEP. 13, 1924 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country)
RUSSIA **Funeral** 1 □ M 2 🗸 F 213-96-3512 81 Director Usual Residence of Decedent 10c. City, Town or Location worde. 10a. State 10b. County 10d. Inside City Limits ir than "natural", or iteme 23a or 28a-f ehov the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5715 PARK HEIGHTS AVENUE #406 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 □Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No WHITE Specify: 2 Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 end 2 should be filed v
Department of Health and Mental Hygies important: If item 27 is marked other it any injury or other traumstic event, the sonce. HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LEYZEROVICH KLARA **PASTERNAK** BORIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 MERINO COURT - OWINGS MILLS, MD 21117 BELLA BRIK / DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ARLINGTON CHIZUK AMUNO 11/01/2005 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of many language Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CEREBRO VASCULAR ATHERO SCLEROTIC Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ig physicien and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HUPERTENSION Records, Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No this certificete has been si al director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 1 Yes 2 No of Vital 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No funeral 27. Mapner of Death To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director; After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

3 State Registrar

31. Date filed (Month, Day, Year)

MISNEEM

29b. Signature and title of certifier

Lashow

7220

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AKHANI,

32. Registrar's Signature

128595

29d. Date signed (Month, Day, Year)

HEKTHIS AVE, BACIO MD 21208

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 5 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 3: 45 PM **Physician** 31 Lemonaki 200 beorge /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Bayview Care Center NIA If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 102M 2□F **Funeral** Min. 95-18 1 ptember 1.192 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director Baltimore undalk 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ 21222 itams 23a NOOLK avenue 1418 by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 In Yes 2 □ No If Yes, Give Year or Dates: WW ☐ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Neyer Married 2 Married 1 Yes 2 No white Specify: Baltimore, Maryland 21215-0036 ŏ Specify: 3 Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If itam 27 is marked other than "na any injury or other traumatic event, It.a Maulic once. Elementary/Secondary (0-12) College (1-4or 5+) Greneral MotoRS Maintenance 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sterais Lemonakis

19a. Informant's me/Relationship (Type, Print) Katena 5 Koloukis ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8927 Cackold POINT Rd, Millers Island, MD 21219 GielNer-20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition

1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State Greek Orthodox Cemekry, Nov. 3, 2005 Bulhimore, MS \* 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facility
Bradley - Mishton Funeral Home, P.A.
2134 Willow Spring Rd. 21222
Approx 21. Signature of Funeral Service Lice 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner promoure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Examiner use as the burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Duknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown as 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an wa. autops, performe 1 ☐ Yes 2 ☐ No 1 Yes Tracheostomy de 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2XN0 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of beath 28b. Time of 5 Pending 1 Anatural 2 Accident 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily)

o the Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Records, Division of Vital Director: d in by the within 24 hours a To the Funeral 6

Certification: To 6 Could not be determined 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200

5505 Hopkins

Baltimove,

October 31,2005 Boy Viow Circle

Overnoughtu 1

Day, Year) 32.9 distrar's Signature Wis 31. Date filed (Month, Day, Year)

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2005

State

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiege of prints.

		1 - For State Registrar	State of Ma	ryland / Di	epartment of the Certificate of	neaith and Mi Death		2005	35481
Physici /Medi		1. Decedent's Name (First, Middle, La		'AHAN			2. Date of Death Month	Day Yes 7 200	3. Time of Death
Examir		4a. Facility Name (If not institution, given A. A. A. A. A. A. A. A. A. A. A. A. A.				or Location of Death		4c. County of D	eath
- Funeral	38	Anne Arundel Count  5. Social Security Number 6.5		enter (In yrs. last birth		If Under 24 Hrs.	9. Date of Birth		Arundel
Director			I □ M 2 🔀 F	61 Yr	Months Dave	Hours Min.	(Month, Day, Y	ear)	Birthplace (State or Foreign Country) Maryland
nyland how		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
e Ma	ctor	Maryland Anne Ar	undel	Deal	e				1 ☐ Yes 2 No
th with th 23a or 21 and De no	Funeral Director	10e, Street and Number 717 Mason Be	eich Road		10f. Zip Code	5i	10g	Citizen of What	Country?
Iryland 21215-0036 should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or Items 23a or 28a-f show matic event, the Madical Examinal must be notified at	by Funer	11. Marital Status  1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1  Yes 2 No. If Yes, Give Year or Dates:		13. Was Decedent of I If Yes, specify Cub		ify Yes or No- ican, etc.)	14. Race - Ai Black, W Specify: W	
5-0036 72 hours af natural; or	ted	15. Decedent's E	ducation (A1)	16a. D	ecedent's Usual Occu	pation	16	b. Kind of Busine	ss/Industry
2121 ad within griene. er than "	Completed by	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+		Give kind of work done fe. DO NOT use retire	during most of working d)			
d 2. filed v Hygie other ti	e Co	17. Father's Name (First, Middle, Last	}		Cashier	18. Mother's Name		Grocery	Store
E da E S	To Be		erryman			Ros			
2 shour and Mis mark	-	19a. Informant's Nama/Relationship (		19b. N	Mailing Address (Street				a, Zip Code)
re, Maryle		Chester McClanahar	Jr./Husha		Mason Bo				
Baltimore, permit. Pages 1 ar Department of Hea mportant: if Itam; iny injury or other		20a. Method of Disposition 1  Burial 2  Cremation 3		20b. Place of D cemetery,	isposition (Name of crematory or other pla	ce) Da	te 200	c. Location - City	or Town, State
tim t. Pag rimen rimit: righty		4. □ Donation 5 □ Other (Specif	y)	Anatomy (	Sifts Registry	Inc.	/2005 F	tanover.	MD
Baltimore, permit. Pages 1 an Department of Heal Important: if Itam 2 any injury or other		21. Signature of Fungeral Service Lice	1500		22. Name and Addre	ess of Facility Ay Gifts Reals ONNalizy 313	THE STE	P.	
Physician _/Medical		23a. Part1. Enter the disease, or com shock, or heart faiture. List only Immediate Cause (Final disease or condition resulting in death)	a	) <u>.</u>	enter the mode of dyin	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
Examiner	Jer	Sequentially list conditions, it any leading to min additionable. Enter Underlying Cause (Disease or injury	b	norisaquenee of):					
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difficate be executed right physicien and as the burial-transit		resulting in death) cast	Due to (or as a	consequence of):					
nd ph	Medicai	IF FEMALE:						100	
the death certificate be executed the attending physicien and sched for use as the buriat-transit	Physician/	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at ti 9□Unknown	Fetel death	3 □Ectopic pregnancy 5 □ Other (specify) _	/		23d. Date of d Month	delivery Day Year
	by P	Part II. Other significant conditions of	ontributing to death but	not resulting in th	e underlying cause giv	en in Part I.	23e. Did tobace	co use contribute	to the cause of death?
w requires to been signer should be a							1 Yes	2 No 3 1	Probably 4 Unknown
The large to page 2	Completed						24a. Was an autopsy performed	death?	autopsy findings available occompletion of cause of
Or VICAL F Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?				26. Place of Death (			
Physical direction	2	1 ☐ Yes 2 No  27. Manner of Death	Hospitaf: 1 Inpatient 28a. Date of Injury		tient 3 DOA Oth	4 1 Harsing Floring			pecify)
Attending Physician: r death. ector: After this certific by the funeral director.	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) 28b. Time Inju	ry Wor	y at k? Yes 2 □ No	d. Describe how in	njury occurred	
LIVISION  If or Attending after death.  I Director: After d in by the fune	Certification:	3 Suicide 6 Could not be determined		/ - At home, farm, (Specify)	street, factory, office		Location (Street City or Town, St	and Number or I late)	Rural Route Number,
	edical C	29a. Certifier (Check only one)	ysician: To the best of liner: On the basis of e and manner state	xamination and/o	eath occurred at the tin r investigation, in my o	ne, date and place, and pinion, death occurred	d due to the cause at the time, date	e(s) and manner a and place, and di	as stated. ue to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier	1	1 .	29c. License	e number	29d.	Date signed (Mor	nth, Day, Year)
		Marvey 1-	Kurkli	110	00	5158	/	1/1/	2005
3		30. Name and address of person who of	completed cause of dea	th (Item 23a) (Typ	5H101	SHADE M	1 5.0e	2076	4.
Stat Registra	e ar	29b. Signature and title of certifier  Across of person who of the control of the	32. Redistrar	s Signature	book				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vaar **Physician** MASSEY HIIFY OCTOBER 27, 2005 7:45 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 716 Fairview Avenue Takoma Park If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Min. 1 M 2 □ F Hours Yrs 97 07 31 South Carolina 197-05-8755 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at MOntgomery MD Takoma PArk 1 X Yes 2 No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20912 USA 716 Fairview Avenue Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritat Status TY'es 2□NoWW II Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1☐ Yes 21X No Specify: Black Specify þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than Elementary/Secondary (0-12) Cotlege (1-4or 5+) Massey Quality Cleaners 8th. Tailor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 2008. Be Eliza McIlwain Robert Massey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 716 Fairview Ave. Takoma Park, MD. 20912 Huenita Massey/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Arlington, VA. Arlington National 11-09-05 \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licensee 4217 9th. St. N.W. Washington, D.C. 20011 o naisha 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock for heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PROSTATE CANCER /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P. 0. 9 Unknown 9 Unknown is been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ▼ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed? certificate 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Certification: To 1 ☐ Yes 2 🙀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify, this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending Injury 1 □ Yes 2 □ No death. investigation 2 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours after To the Funeref Dire 1 XCartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier #MD 33255 OCTOBER 28, 2005 6

DHMH 17 Rev 1/2001

State

Registrar

M.D. VA MEDICAL CENTER, 50 IRVING STREET NW, WASHINGTON, DC 20422

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

KAREN ANN BLACKSTONE,

NOV 0

31. Date filed (Month, Day, Year)

			For State Registrar		State of	Maryla	and / Dep <i>Ce</i>	artment <i>rtificate</i>			l Menta		ene) (	05 (	35483
			1. Decedent's Name	(First, Middle,	Last)							e of Death	0	Year	3. Time of Death
	Physici /Medio	7			11e McDow			,			0ct	ober	<u> </u>	2005 <sup>ar</sup>	7:41 P M
	Examir		4a. Facility Name (If	not institution,	give street and num	ber)		4b. City, T	own, or L	ocation of Dea	ath			unty of Death	
y			10719 Kit 5. Social Security Nu			Ago /le v	rs. last birthday,			7 <b>ille</b> If Under 24 Hr	rs. 8 Date	e of Rirth		nce Ge	orge s
	Funeral Director		Unknown	IIID9i	1 □ M 2 1 F	. 790 (111 )	Ven	Months	Days	Hours Mi	n. (Mo.	e of Birth onth, Day,	Year) <b>91</b>	Coui	erly, MD.
· .			Usual Residence of I	Decedent				1							
	ylanc		10a. State	10b. County		10c.	City, Town or L	ocation						1	0d. Inside City Limits  12 Yes 2 No
	8 Ma	cto	MD	Prince	Georges		Bowie								
	vith th	Director	10e. Street and Num					10f. Zip (				10		of What Cou	ntry?
	death with the Maryland me 23a or 28a-f ahow r must be notitied at	rai	10719 K	itchne	r Court	lant Ever is	11 6 12		716	panic Origin?	(Specify Ve	s or No.		JSA Race - Ameri	can Indian
36	atter or Ite	by Funeral	11. Marital Status  1   Never Marrie  3   Widowed 4		Armed Ford	ces? 2 ⊠ No	10.3.	If Yes, speci	y Cuban,	Mexican, Pue	erto Rican, e	etc.)		Black, White, ec <i>ify:</i> Blac	etc.
Ö	72 hours "natural", policel Exe	edi		15. Decedent'	s Education		16a. Dece	dent's Usual	Occupati	ion	4:	1	6b. Kind o	of Business/In	dustry
215	C	Completed	(Specif		grade completed) College (1-	4or 5+)	life.	DO NOT use	done du retired)	ring most of w	vorking				
21	illed within Hygiene. other then	Com	9th					Stude							
Pu	be filed withing Hygiene.	Be (	17. Father's Name (F						1	8. Mother's N			aiden Sun	name)	
yla	Men Men marke marke	၉	Tyrone		-				(2)		he MA		0't T.	Carata Zia	- C- d-)
Maryland 21215-0036	12 sh h and r is m	Ø Î	19a. Informant's Nar Sandra MA			•				Rd. St			-		
	permit. Pages 1 and 2 should be fill Department of Health and Mental H Important: If Item 27 is marked ott any Injury or other treumatic even once.		20a. Method of Dispo		andmother		o. Place of Disp	osition (Nami	9 of		Date			on - City or To	
Baltimore,	ages nt of l		1 ⊠ Burial 2 🗀	Cremation	3 Removal from S	tate	cemetery, cre [Aryland		-		28-05			1, MD.	
턆	artme artme orten! Injury		4 □ Donation :			ļ P				of Facility M					me
Ba	Deparent Impo		100	has	make of	2				st. N.W					
1	Physician		shock for heart Immediate Cause (F	ttailure. List o Final	complications that ca inly one cause on ea	ch line.			of dying,	such as cardi	iac or re <i>s</i> pir	atory arre	st,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	3	a. Due to (c	( 10 -	sequence of):	1							
-	Examiner		Sequentially list con	ditions,	b			•							
	p is	luei	Sequentially list con cause. Enter Under Cause (Disease or in	mediate tying	Due to (c	or as a cons	sequence of):								
V	be executed ician and burial-translt	Examiner	that initiated events resulting in death) La		c	or as a cons	sequence of):								
8760,	be exician buria														
687	ficate p physics the	edical			0								-1		
Box	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	by Physician/M	IF FEMALE: 23b. Was decedent in the past 12 r 1  Yes 2  9	nonths?		ntattime o	etal death 3	⊒Ectopic pre ⊒ Other (spe					23d.	Date of delive Month	ery Day Year
P.0	that the led by th detach	P.	Part II. Other signific	cant condition	s contributing to de	ath but not	resulting in the i	underlying ca	u <i>s</i> e given	in Part I.	23	e. Did toba	acco use o	contribute to t	he cause of death?
ds	uires sign ld be	d b										1 ☐ Yes	2 N	o 3 ☐ Prot	oably 4 ∐Unknown
Vital Records,	w requir been si should	Completed									24	a. Was an		4b. Were auto	ppsy findings available
Re	The larate has	E										autopsy perform Yes 2	ed?	death?	mpletion of cause of 2□ No
tal		0	25. Was case referre	ed to medical						26. Place of D		_		194100	20.10
2	Attanding Physicien: r death. sctor: After this certific by the funeral director,	To B	examiner? M∑Yes 2 ☐ N	No	Hospital: 1 🗆 In	patient 2	ER/Outpatie	nt 3□ DO/	Other	4 🗌 Nursing	Home 5	Resider	nce 6 🔯	Other (Specia	y)at scene
Division of	ding Ph h. After th funeral	ü.	27. Manner of Death	5 🗌 Pending	28a. Date o	f Injury i, Day Year	28b. Time (	of 28	c. Injury a Work?	at	28d. De	scribe hov			1 = = 1
<u>S</u>	Attandir death. ctor: Al y the fu	Certification:	2 Accident	investig	ation 10 (3	-3/05	7:24	P M	1 □ Y€	9s 2 No	Su	hje		<i>L</i>	d selt
Ξ̈́	or Att	Ĕ	3 🏿 Suicide 4 □ Homicide	determi	286. Place	of Injury - A g, etc. (Sp	it home, farm, si				City	y or Town,	State)	07191	al Route Number, Litchever Ct
Q	urs at							dinc			H	1+ch	cilui	He M	·D
	To the Hospitel or Attanowithin 24 hours after death To the Funeral Director: completely filled in by the	Medical			Physician: To the lixaminer: On the ba and mann	sis of exam									
	To the within 2 To the complet	Me	29b. Signature and t	title of certifier	W. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.			29c.	License			29	d. Date si	gned (Month,	Day, Year)
	⊢ s⊢ ŏ		MAR	de	Marc.	1 i	wel		OCME			C	ctob	er 24,	2005
	Λ.		30. Name and addre	ess of person v	no completed cause	of death (	Item 23a) (Type	, Print) 11	1 Pe	nn Str	eet I				and 21201
	2		CH	rec	Htte.	410	Med			- 66			- ,	-3-	
	Sta	ite	31. Date filed (Monti	h, Day, Year)	32. Re	gistrar's Si				7.7					
	Regist	ar		NOV	0 3 2005	Mar.	and At	Long	12						
DH	MH 17 Rev 1/2	001				-		and the same of th							

ORIGINAL

DHMH 17 Rev 1/2001

State Registra

**ORIGINAL** 

21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles St. Bultimore MI

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please	Type or	Print in	Black	Indelible Ink.	Ensure	All	Copies	Are	Legible.
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			For State Registrar	State of M	Maryland /	Depa Cer	irtment of H	ealth a D <i>eath</i>	ind M		giene () ()	15	35486
10			Decedent's Name (First, Middle, La	st)						2. Date of Dea Month		V	3. Time of Death
	Physici /Medio		Helen Gregg M	cDonald						Novamb		Year 2005	250 AM
A STATE	Examir		4a. Facility Name (If not institution, give Sinai Hospetal		timore		4b. City, Town, or Balter				4c. County	of Death	
3	Funeral Director		307-20-3504	Sex 7. /	Age (In yrs. last l	Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day Feb 18	3, Year) 922	9. Birthpi Coun	ace (State or Foreign try) Scotland
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation					10	0d. Inside City Limits
	Maryl. f eho	to	MD Prince G	eorges	Colle	ae Pa	ark						1 ☐ Yes 2 ☑ No
	r 28e	lrec	10e. Street and Number	coi ges		<u> </u>	10f. Zip Code				10g. Citizen of V	What Coun	try?
	23a o	a D	9800 Cherry Hill	Road			20740				USA		
36	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "naturel", or liems 23a or 28e-f ehow event, the Medical Examerer must be motilled at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒Divorced	12. Was Deceder Amed Force 1 Yes 20 If Yes, Give Year or Dates	s? ] No	If	Vas Decedent of Hi Yes, specify Cubar	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)		e - Americ ck, White, e	etc.
ŏ	2 hou	ted	15. Decedent's E		16	a. Deced	ent's Usual Occupa	ition	of work in	10	16b. Kind of Bu	usiness/Ind	lustry
218	thin 7	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4o	or 5+)	life. D	OO NOT use retired,	uring mosi	OF WORKIN	ig	0 11		
21	filed wi Hygien Sther th		8	1	H	omema	aker	19 Motho	r's Nama	/First Middle	Own Hon		
Maryland 21215-0036	2 should be filed within and Mental Hygiene. Is marked other then eumatic event, the Me	Be	17. Father's Name (First, Middle, Last, Alexander Greg					Marga			iamson	10)	
<u>F</u>	iges 1 and 2 should but of Health and Ment: If item 27 is marked or other treumatice	ပ	19a. Informant's Name/Relationship (		19	9b. Mailin	g Address (Street a					State, Zip	Code)
	and 2: ealth ar n 27 is		James R. McDonald	/ s	on 1	4625	Baltimor	e Ave	nue	#117; 1	aurel,	MD 20	0707
ore,	of He of He r othe		20a. Method of Disposition  1 ABurial 2 Cremation 3	Pamoval from Sta	20b. Place ceme	of Dispos tery, crem	sition (Name of natory or other place	9)	Di	ate	20c. Location -	City or To	wn, State
Ē	Pages ment of I ant: If its ury or o		4 Donation 5 Other (Special			awn (	Cemetery	1	1/5/	05	Detroit		
Baltimore,	permit. Page Depertment of Important: If eny injury or		21. Signature of Funeral Service Lice	- almy		Ru	Name and Addres	Fune	ral		1050 Y Towsor		
п			23a. Part1. Enter the disease, or com shock, or heart failure. List onty	plications the caus one cause on each	ed the death. Do	o not ente	er the mode of dying	g, such as	cardiac or	r respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	Sep	515	•						
	/Medical Examiner		Todating in doubly	Due to (or a	as a consequênc	e of):							
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	as a consequenc	e of):							
V	outed nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c									
oʻ	be executed sicien and burial-transit	Ex	resulting in death) Last	Due to (or a	as a consequenc	e of):							
8760	ohysic the bu	dlcal	•	d					-				
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		2 Fetal dea at time of death		Ectopic pregnancy Other (specify)				23d. Dat	e of delive	ry Day Year
, P.O.	es that the igned by be detact	by Ph	Part II. Dther significant conditions	contributing to death	but not resulting	in the un	derlying cause give	n in Part I.		23e. Did to	bacco use cont	ribute to th	e cause of death?
ırds	w require been sig should b	ted t		· · · · · · · · · · · · · · · · · · ·				<del></del>		1 🗆 Y	es 2□No	3 Proba	ably 41 onknown
Records,		Completed							_	24a. Was a autop perfor 1 Yes	med?	Were autoporior to condeath?	osy findings available inpletion of cause of 2 No.
of Vital	Physician: This certificeral director, p	Be (	25. Was case referred to medical examiner?				i au		of Death	(Check only o	ne)		
of	this at di	၉	1 Yes 2 No	Hospital: 1 ☐ Inpa 28a. Date of Ir		Outpatient		4 🗆 Nui			ence 6 Other		)
on	After After	tlon	1 Accident 5 Pending 2 Accident investigatio	(Month, L	Day Year)	Injury	28c. Injury Work	al ? ′es 2.⊟N		od. Describe n	ow miluty occurr	<del>a</del> u	
Division	To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could not b	e 28e. Place of	Injury - At home, etc. (Specify)	farm, stre				8f. Location (S City or Tow	treet and Numb n, State)	er or Rural	Route Number,
	ne Hospita 124 hours ne Funerel letely filler	Medical C	(Check only 2 Medical Exam	nysician: To the be miner: On the basis and manner	of examination	and/or inv	estigation, in my op	inion, deat	h occurre	d at the time, o	date and place, a	and due to	the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	80	n n		29c. License	number	~		29d. Date signed	d (Month, L	Day, Year)
			yahm ///	W	TILINI		1)005	448	1	/	Vovem	ber	1,2005
	1		30. Name and address of person who Patrick M (6)	completed cause on lay MD	f death (Item 23a	1) (Type, I	est bolv	edor	e Au	i. B	altimore	2,1	1,2005 MD 21215
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regi	strar' Signature	A	Joseph !						

Physici		Registrar			Ce	rtificate of	Death		Reg	, No. U U	5	3548	5 /
/Medic		Decedent's Name (First, Mid		race Pfe	eiffer Melle	or		2.	Date of Death Month	Day Der 30, 20	Year	3. Time of Di 1:50 a.	
Examir		4a. Facility Name (If not institut	ion, give street	and number)		4b. City, Town,	or Location of	Death	00.01	4c. County		1	
			Oak	Crest Villa	ge			Park	ville		Bal	timore	
Funeral	= =13	5. Social Security Number	6. Sex 1 ☐ M 2		(In yrs. last birthday)	If Under 1 Year Months Days		4 Hrs. 8. Min.	Date of Birth (Month, Day, Y	(ear)	9. Birthp	place (State or F	oreign
Director		212-20-6415	10.00	241	81 Yrs.				October 3.			Maryland	
<b>*</b>		Usual Residence of Decedent  10a. State 10b. Coun	ity		10c. City, Town or Lo	ocation						0d. Inside City	Limite
or 28a-f show se notified at	ō	Mondond	Dalkinsa		*		<b>D</b> 1 30					1 Yes 2	
28a	rect	Maryland  10e. Street and Number	Baltimo	ie		10f. Zip Code	Parkville		100	. Citizen of V	Vhat Cour		
MIT DE	0	8810 Walther Blv	ıd				212	34	.09	, OKIZOI 01 V	U.S	•	
CONTRACTOR	era	11. Marital Status	12. W	as Decedent Ev	ver in U.S. 13.	Was Decedent of If Yes, specify Cub			Yes or No-	14. Race		an Indian.	
nny injury or other traumatic event. The Mudical Examinar must be notified at once.	by Funeral Director	1 Never Married 2 Mi	arned 1	med Forces? □Yes 21X No Yes, Give ear or Dates:		If Yes, specify Cut 1 □ Yes 2 2 No		Puèrto Ric	an, etc.)		k, White,		
9		15. Deced	ent's Education		16a, Dece	dent's Usual Occu	pation		16	Sb. Kind of Bu	isiness/lnr		
New Company	Completed	(Specify only high Elementary/Secondary (0-12	nest grade com	pleted)	(Give	kind of work done DO NOT use retire	durina most c	of working	10	D. Killa of Da		spaper	
	E O	12	,	ollege (1-4or 5+)	,	Adve	rtising Ma	nger			MEMS	paper	
Ä,	a	17. Father's Name (First, Middle	e, Last)				T		irst, Middle, Ma	iden Sumam	e)		
tice)	To B	Herb	ert Thoma	s Pfeiffer					Lillian	E. Smallv	wood		
aumatic event, the Ms	74	19a. Informant's Name/Relation	nship (Type, Pi	rint)	19b. Maili	ng Address (Stree	t and Number	or Rural R	oute Number, C	City or Town,	State, Zip	Code)	
ar tra		Ms. Patricia Ho	offman	Daught	er	5127 W. Hea	aps Rd. P	ylesville	, Maryland	21132			
oth		20a. Method of Disposition		-	20b. Place of Dispo	osition (Name of matory or other pla	acel	Date	20	c. Location -	City or To	wn, State	
Important: If Item 27 i any injury or other tri <u>once.</u>		1 Burial 2 ☐ Cremation 4 ☐ Dopation 5 ☐ Other		altrom State		Chapel Cen	1	11/05	6/2005	Pfeiffer	rs Corr	er, Maryla	nd
y inju		21. Signature of Funeral Service	e License	. /		2. Name and Addr						,	
Important: If any injury or once.		Melevalesta	m Sl	al por	2753-	Slack	Funeral H	lome, l	P.A. <del>(e Ellicott (</del>	0			
		23a. Part1. Enter the disease, shock, or heart failure.	complication	s that caused th	ne death. Do not en	er the mode of dy	ing, such as ca	nbla Pli ardiac or re	Spiratory arrest	ity, MD	21043	Approximate	
sician		Immediate Cause (Final	st only one cau	ise on each line.	- (		eve					Onset and Dea	en ath
edical		disease or condition resulting in death)	a	End	Stace								
niner				Due to for as a		1) 6	evne	~ ~ ~					
				Due to (or as a	consequence of):	() (	zme					-	
	er	Sequentially list conditions, if any, leading to immediate	b	,		126	en ei						
1.0	miner	Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	,	consequence of):	100							
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the burial-transit	dlcai Ex	IF FEMALE:	b c d	Due to (or as a o	consequence of): consequence of): consequence of): pregnancy					23d. Date	a of delive	N.	
	dlcai Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	b c. d. 23c. lf 11	Due to (or as a o	consequence of):  consequence of):  pregnancy  Fetal death 3 5	□Ectopic pregnanc				23d. Date Mon	e of delive	ry Day Yea	ır
the burial-transit	dlcai Ex	IF FEMALE: 23b. Was decedent pregnant	b c. d. 23c. lf 1 14	Due to (or as a of the control of th	consequence of):  consequence of):  pregnancy  Fetal death 3 5	⊒Ectopic pregnanc				1		_	ır
the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \)	b c. d. 23c. lf y 11 40 90	Due to (or as a or yes, outcome of Live birth 2 Pregnant at tir Unknown	consequence of):  consequence of):  pregnancy  Fetal death  of death  5	]Ectopic pregnanc ] Other (specify) _	:y			Mon	nth	_	
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ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  Part II. Dther significant condi	b c. d. 23c. if y 11 4[ 9[	Due to (or as a or yes, outcome of Live birth 2 Pregnant at tir Unknown	consequence of):  consequence of):  pregnancy  Fetal death  of death  5	]Ectopic pregnanc ] Other (specify) _	cy ven in Part I.		23e. Did tobac  1  Yes  24a. Was an autopsy performe 1 Yes 2 La	Mon  cco use contri  2 No  24b. W	ibute to th	e cause of deal ably 4 4 bright	th?
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Hellor, Grace 10/30/05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra ReginoU Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** OROTHY MAY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNAPOLIS ANNE ARUNDEL INNEARUNDEL MEDICAL CENTER Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Year) Months Days Hours 1□M 2 🗗 F 9 215-03-6330 MARYLAND Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ₩ No Directo ANNE ARUNDE ASADENA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 21122 .S.A. "natural", or Items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: JHITE 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. TORYL 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Name/Relationship (Type, Print) REMEN RD. PASADENA, MD permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trat once. 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State VIEW CREMATORY YTIMORE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** onuemonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transi attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months?
1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) the 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No certificate 1 Yes 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐Other (Specify) 3 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: after death. Director: After t 1 Hatural 2 Accident 5 Pending investigation 1 Yes 2  $\square$  No the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month) Day, Year) 29c. License number 05 and address of perso 1

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Registrar's Signature 32

**ORIGINAL** 

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Maryland 21215-0036

Baltimore,

P.O. I

of Vital Records,

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie [ ] 5 35489 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month NOV. 10:29P.N **Physician** ALLEN AIGE 2005 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TIHORE GILCHRIST HOSPICE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days 1⊠M 2□ F 247-44-805 Yrs. 30 South Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No MARYLAND Direct 10g. Citizen of What Country? 10e. Street and Number ō 30 AVENUE or Itema 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 XYes 2 ☐ No If Yes, Give 1 Never Married 2 Marned 1 Yes 22 No Specify: BLACK Completed by 3X Widowed 4 ☐ Divorced Year or Dates "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. ould be filed within Mental Hyojene. Elementary/Secondary (0-12) College (1-4or 5+) MPUTER I TH GRADE ANALUST SPARROWS 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be it of Health and Menta KUTH 2 AIGE 19b. Mailing Address (Street and Number or Rural Poute Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SHIRLEY JOHNSON (GIRL FRIEND) 4306 SHELDON BALTIMORE MD. 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) Date / 20c. Location - City or Town, State Pages 1 20a. Method of Disposition 1 Ø-8urial 2 ☐ Cremation 3 ☐ Removal from State FOREST 11-09-05 OWINGS MILLS, MD GARRISON 4 ☐ Donation 5 ☐ Other (Specify) BROWN JR. FUNERAL HOME 21. Signature of Funeral Serviçe Licensee 22. Name and Address of Faculty FULTON AVE. , BALTO, MD. 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) - Ancek 0 **Physician** /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ō Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 🗆 No 3 Probably 4 □Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Director: After th 27. Manner of Death 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? Medical Certification: 5 Pending investigation 1 Natural 2 🗌 No death. 1 Yes 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in To the Hospital 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and fittle of Certifier 29c. License number Vousaber 2, 2003 und cause of seath (Item 23a) (Type, Print) 30. Name and address of person who completed Charles St. Balto, Md 670 K 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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			1 - For State Registrar	State of Maryland / Depa	artment of Health and rtificate of Death		2000 00400
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Ī	Funeral			. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min.		9. Birthplace (State or Foreign Country)
	Director	C	Usual Residence of Decedent	1 4 4 Yrs.		12-5-3	5 Washington, D.C.
	aryland show	_	10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits 1 ▼Yes 2 □ No
	ith the Marylar or 28a-f show a notified at	recto	10e. Street and Number	Baltin	10f. Zip Code	100	D. Citizen of What Country?
	23a or	al DI	4797. Sham	Mock Avenue	21206		USA
	after death w or items 23a	by Funeral Director	11. Marital Status 1 Never Married 2  Marrie	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
5-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show the Modical Examiner must be notified at	l by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Blad
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-	1 and 2 s Health ar em 27 ls ther trau		Kevin-P.Jack	son (SON) 479	7 Shamrock	Aveil	Batto MA21206
Baltimore	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other to once.		20a. Method of Disposition  1 Curial 2 Cremation 3	Hemoval from State	osition (Name of matory or other place)	Date 20	c. Location - City or Town, State
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ŀ	- Sta Registr	te ar	31. Date filed (Month, Day, Year)	and manner stated.  MD  To completed cause of death (Item 23a) (Type.  XIT , 5601 LOCH 1  32. Registrar's Signature	Goods (		
- 0	Registr	ar	NOV 0	3 ZUUD Killinger da da	The state of the s		

State of Maryland / Department of Health and Mental Hygierie 15 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10 **Physician** 2005 Poole 3:00 a M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Emerald Estate Assisted Living Baltimore Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year **Funeral**  Birthplace (State or Foreign Country) 1 M 2 F Director 214-28-4598 Yrs. 72 March 9, Pennsylvania Usual Residence of Decedent the Maryland 10a. State show 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 ☐ No 288-1 Maryland Baltimore Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ö 3855 Green Spring Avenue 21211 U.S.A. or Items 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ont: if item 27 te marked other than "natural", or Ite Black, White, etc. 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: ð Specify: White 3x Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Owned Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Merle Clemmer ပ Florence Dorris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: if item 27 is any injury or other tre <u>once.</u> Vicky Poole/Daughter 1120 South Highland Ave. Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Ø her (Specify) George Washington 10/21/2005 Adelphi, Maryland 21. Signal Funeral ervice Licensee 22. Name and Address of Facility Fleck Funeral Home 7601 Sandy Spring Road Laurel, Maryland 20707 Vous 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cancer of the Lungs resulting in death) /Medical Due to (or as a consequence of): Examiner Chronis Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Seizurs that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Records. sign be Brain Tumor page 2 should Be Completed 1 ☐ Yes 2 ☐ XNo 3 Probably 4 Unknown Gastroesophgeal Reflux 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2€ No Division of Vital 1 ☐ Yes Hospitel or Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify 1 1 1 ng Certification: To 1 ☐ Yes 2 🕱 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending 24 hours after death. Funeral Director: A investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only within 2 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 10/28/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ambautew Woreta, MD 2431 Maryland Ave. Baltimore, Maryland 21223 31. Date filed (Month, Day, Year) 32. Resistrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

2005

NOV 0 3

			1 - For State Registrar	State of Mi	aryland / Depa <i>Cel</i>	rtificate of			Reg. No.	15	3545	12
			Decedent's Name (First, Middle, Las	t)				2. Date of Dea		Year	3. Time of	Death
	Physici /Medic		Beatrice W. F	loyster				October	-	2005	5:30	$A^{M}$
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. Coun	ity of Death	1	
			Lorien Nursing Ho				ltimore					
	Funeral		5. Social Security Number 6. So	ax 7.Ag ⊒M 2□XF	e (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day		9. Birth	place (State o. Intry)	r Foreign
н	Director		220-24-9829 Usual Residence of Decedent	*	78	<u> </u>		05/19/1	927	Tenn	essee	
	/land		10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside Cit	•
	Man,	ţċ	Maryland		]	Baltimore					1 XYes	2 🗆 No
	th the	lrec	10e. Street and Number		,,	10f. Zip Code			10g. Citizen o	f What Cou	intry?	
	23a c	alD	4303 Marble Hall	Road Apt	. 111	21239				S.A.		
	r dea	nel	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra BI	ace - Amer lack, White	ican Indian, , etc.	
36	s afte	y F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🐴 N If Yes, Give	40	1 ☐ Yes 2 No	Specify:		Spec	ify: Bla	ack	
9	tiled within 72 hours after death with the Maryland Hygiene. kther than "natural", or ttems 23a or 28a-f ehow ent, tra Medical Examirer mast be multilied at	Completed by Funeral Director	15. Decedent's Ed	Year or Dates:	16a. Dece	dent's Usual Occup	ation		16b. Kind of	Business/Ir	ndustry	
15	in 72 n "na Nedic	piet	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5	(Give	kind of work done DO NOT use retired	during most of work d)	ing			,	
212	filed within Hygiene.	E	10	College (1-401 S	Mac	hine Ope	rator		Prin	ting		
b	be file ital Hy id othe event,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Suma	ame)		
yla	should be and Mental is marked c	10	D. Pankey				Margaret	M. Wil	liams			
Maryland 21215-0036	2 sho		19a. Informant's Name/Relationship (7				and Number or Run					
	1 and Health em 27 ther tr		Margaret Jefferso  20a. Method of Disposition	n / Daught	20b. Place of Dispo	Clareway	Apt. 2 J	, Baltin	20c. Location	Maryl	and 212	113
Baltimore,	of of		1 ∰Burial 2 ☐ Cremation 3 ☐		cemetery, crer	natory or other place. Cemeter	ce)	/2005				d
Ħ	permit. Page Department of Important: If any injury or once.		<ul><li>4 □ Donation 5 □ Other (Specify</li><li>21. Signature of Funeral Service Ligen</li></ul>				,					
Ba	permit. Departr Importa any inj		21. Sign tidle of Punetal Service Light				ss of Facility The					
			23a. Part1. Enter the disease, or comp	lications that sused	the death. Do not ent					lar y 1.	Approximate Interval Betv	
	Dhamisian		shock, or heart failure. List only of Immediate Cause (Final				0	1.11.56			Onset and D	eath
4.	Physician / /Medical		disease or condition resulting in death)		NO CARC	inomit	01-	LUNG			= 6 m	on the
	Examiner		Convention to the tips and tisteen	b								
. 7	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):		·					
٧	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C								
60,	cate be executed physician and the burial-transit		333	Due to (or as	a consequence of):							
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	<b>l</b> edical	•	d								
_	certific nding p	√/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. D	ate of deliv	erv	
Вох	death cert attendin	clar	in the past 12 months?	4□Pregnant at		Ectopic pregnancy Other (specify)				lonth		ear
P.O.	that the death cer ed by the attendir detached for use	Physician/N	9 Unknown	9□ Unknown								
	res tha igned l	by P	Part II. Other significant conditions of					23e. Did tol	bacco use cor	ntribute to t	he cause of de	ath?
ig	w require been sig should b	ed	CHRONIC OB	iTRUCT 1	E LUN	a DIST	ATE_	1 □ Ye	es 2 No	3 Pro	bably 4 U	nknown
ဝ၁	e law requ has been le 2 shoul	piet						24a. Was a autops	n 24b.	. Were auto	opsy findings a	vailable use of
Ä	The I	Completed						perforr	ήed? 2. No	death?	2 No	
/ita	sician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?				26. Place of Death	n (Chack only on	(e)			
of Vital Records,	Phys this al dir	To	1 Yes 2 0	Hospital: 1 Inpatie			4 Mursing Ho	me 5 Reside			fy)	
N C	ding F h. After funera	lon:	1 atural 5 Pending	28a. Date of Injui (Month, Day	Year) 28b. Time of Injury	28c. Injun Worl	y at k? Yes 2 □ No	28d. Describe ho	ow injury occu	ırrea		
isi	ten leat tor: the	licat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	ury - At home, farm, str			28f. Location (St	reet and Num	ber or Run	al Route Numb	per.
Division	after Direction by	Certification:	4 ☐ Homicide determined	building, etc	:. (Specify)	Jos, sactory, cinco		City or Town				
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier Certifying Phy	sician: To the best	of my knowledge, death examination and/or inv	occurred at the tin	ne, date and place,	and due to the ca	ause(s) and m	nanner as s	tated.	
	ne Ho n 24 { ne Fu	Medical	(Check only 2 Medicel Exam	iner: On the basis of and manner sta	examination and/or in- ited.	restigation, in my o	pinion, death occurr	ed at the time, d	ate and place	, and due t	o the cause(s)	
	To the Hospital within 24 hours a To the Funeral completely filled	M	29b. Signature and title of certifier			29c. License			9d. Date sign			
			Nivelin			D00	60877	8	OCTUB	ER :	31 20	05
	2		30. Name and address of person who d	ompleted cause of de	eath (Item 23a) (Type,	Print)	AV- 201-	20:	Timas	<i></i>	MO.	
			NIVEDITA BANS	AU. 50	09 FRAC	VICFORD	DIEWVIE	13/12	-1 (110 (2)	(=	110,	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 3 200	5 Jace	a Signature	Res.						

State of Maryland / Department of Health and Mental Hygiene 115

		State of Marylar	nd / Department of F Certificate of	lealth and Mental  Death	Hygiene 005 35493
		1. Decedent's Name (First, Middle, Last)		2. Dete d	of Deeth 3. Time of Death
46	Physiciar /Medica	Hazel M. Roberts		10	29 05 5:30A.M.
	Examine	4a Fecility Neme (If not institution, give street and number)	1	4b. City, Town, or Location of I	
		Manor Care Chevy Chase  5. Social Security Number 6. Sex 7. Age (In yrs.	lest hirthday) If Under 1 Year	Chevy Chase,	Montgomery
н	Funeral Director	161-22-5941 1 M 2 DXF 98	Yrs. Months Days	Hours Min. (Mont	of Birth h, Dey, Yeer) 07 07  9. Birthplace (State or Foreign Country) Bellefonte, PA.
	107-	Usuel Residence of Decedent		07	or or beliefonce, FA.
	anylen thow		ty, Town or Location		10d. Inside City Limits
:	vith the Me t or 28a-f s be notified	MD Prince Georges M	itchellville		1X□ Yes 2□ No
	Alth I	10e. Street end Number	10f. Zip Code		10g. Citizen of What Country?
	m 23	1701 China Berry Court  11. Maritel Status  12. Was Decedent Ever in U	20722		USA or No- 14. Race - American Indian,
020	s 1 end 2 should be filed within 72 hours after death with the Merylend if Health end Mantail Hygiana. Ifem 27 is marked other than "nature!, or items 23a or 28a-f show other traumetic event, the Medical Examiner must be notified at The Parket than the Completed by European Please.		If Yes, specify Cube 1 ☐ Yes 2 🛣 No	ispanic Origin? (Specify Yes on Mexican, Puerto Rican, etc Specify:	Specify: Black
21215-0020	2 hou	15. Decedent's Education	16e. Decedent's Usual Occup	ation	16b. Kind of Business/Industry
2	a. a	(Specify only highest grade completed)  Elementery/Secondary (0-12)  College (1-4or 5+)	(Give kind of work done of life. DO NOT use retired	during most or working	
21	be filed within 72 hou tal Hygiana. I dother than "nature event, the Madical E	12th.	Housewife		
gue '	d of the file	17. Father's Neme (First, Middle, Last)  Edward Overton		18. Mother's Name (First, Mi	
Maryland	d Mant d Mant marked matic e	19a. Informant's Name/Relationship (Type, Print)	10h Mailing Address (Street	Emma William	MS lumber, City or Town, State, Zip Code)
<u>∞</u>	Ithen 17 ier 17 ier	Karen Turner/Granddaughter			
<u>ق</u>	is 1 er other	20a Method of Disposition 20b. F	Place of Disposition (Name of cemetery, crematory or other plea	ry Ct. Mitchel	Lville, MD. 20721 20c. Location - City or Town, Stete
Ê,	Pagas nant of I int: If the Iry or o	1 X Burial 2 Cremetion 3 Hemoval from State	eendale Cemeter		-05 Meadville, PA.
Baltimore,	permit. Pagas Department of i Important: If its any Injury or o	21. Signature of Funeral Service Licensee	22. Name and Addre	ss of Facility MArshal	ll's Funeral Home
00	80 5 8	DR marchall	4217 9th.	St. N.W. Washi	ington, D.C. 20011
		23a. Part I Enter the diseese, or complications that caused the deet shoot, or heart failure. List only one cause on each line.	h. Do not enter the mode of dyin	g, such as cardiac or respirate	ory arrest, Approximate Interval Between
	Physician				Onset and Death
	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	or as a consequence of):		
		Due to (c	ir as a consequence of):		2 6 6
	physician and sthat buriel-transit	b. Due to (o	r as a consequence of):	inary mac	t injection
oʻ	an an riel-tr	Sequentially list conditions, if eny, leading to immediate cause. Enter Undertying Ceuse (Disease or injury	. 40 4 00.1004201.100 01/1		
58760,	eta be hysici tha bu	Ceuse (Disease or injury that initiated events Due to (o	r es e consequence of):		
Ø .	ertific ing p	d			
XO RO	v raquiras that the deeth certificets be executed been signed by the attanding physician and should be dateched for use as the buriel-transit letted by Dhvelclan/Medical Examir				
	y the chad	Part II. Other eignificant conditions contributing to death but not res	ulting in the underlying cause give		Did tobacco use contribute to the cause of death?
	as thet igned by be date				1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Vital Records,	law raquiras that the as been signed by the second be dateched by the second by the se				Was an eutopsy performed? 24b. Were eutopsy findings available prior to
ပ္တ	the law raquir cete has been s page 2 should				completion of cause of deeth?
ř	ste he page				1 ☐ Yes 2 D\No 1 ☐ Yes 2 D\No
<u> </u>	nysician: the law is cartificate has but director, page 2 s	25. Was case referred to medical exeminer?	1	26. Plece of Death (Check of	only one)
	Physician: rthis certific rtal director,	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 DOA Oth	4 pg Nursing Home 5 🗆 i	Residence 6 □Other (Specify)
ב ה	After	27. Manner of Deeth  1 Maturel 5 ☐ Pending 2 Accident investigation	28b. Time of lnjury 28c. Injury Work	yat 280. Desc k? Yes 2 □ No	ribe how injury occurred
DIVISION	deeth ctor: y tha	3 Suicide 6 Could not be 28e. Place of Injury - At ho	ome, farm, street, factory, office		ion (Street and Number or Rural Route Number,
3	tel or Attending Price of Stern deeth. el Director: After tad in by the funers	4 ☐ Homicide building, etc. (Specifi	v)	City o	r Town, State)
	To the Hospital or Attending Physicians, within 24 hours effect deeth.  To the Funeral Director: Affer this completely filled in by the funeral dimension.  Medical Certification: Tr	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my kno 2 Medicel Examiner: On the basis of examinal and manner stated.	wledge, death occurred et the tin tion and/or investigetion, in my o	ne, date end place, and due to pinion, death occurred at the ti	the ceuse(s) and manner as stated. ime, date and place, and due to the cause(s)
	Mithin Somple	29b. Signature end title of certifier	29c. License		29d. Date signed (Month. Day, Yeer)
•	7,0		100	054566	10/31/05
	0	30. Name end eddress of person who completed cause of death (Item	1 23e) (Type, Print)		
	9	31. Date filed (Month, Day, Year)  32. Begistrar's Signa	1 Earl JESSCI	Poeid Scel	1230 town MOULIE
	State Registrar	31. Date filed (Month, Day, Year) 32. Régistrar's Signa	ture:	,	

State of Maryland / Department of Health and Mental Hygiene 05

Certificate of Death Reg. No.

35494

			Decedent's Name (First, Middle, Last)			2. Dete of De		3. Time of Death
	Physici		treddie Royster			Month		rear 25 12-30
30	/Media			5 mole	4h City Town	, or Location of Deat		
1	Examir	er	11-00		Hyat			
								1
	Funeral		o. obolar ocounty resistant	If Under 1 Year Months Days		Min. 8. Date of Bir (Month, Da	th s	9. Birthplace (State or Foreign Country) unk
	Director		578-36-3435 1 N 2 F 75 Yrs. 1			Mar 8,	1930	27 UIIK
	B	Ì	Usual Residence of Decedent					
	dan dan dan dan dan dan dan dan dan dan		10a. State 10b. County 10c. City, Town or Local	tion				10d. Inside City Limits
	Se de de	5	DC Washins	ton				1 ☐ Yes 2 ☐ No
	e 8 9	ठ	DC Washing				40- Citizen of 14th	
	5 6 g	ä	10e. Street end Number	10f. Zip Code			10g. Citizen of Wh	
	23a th	Funeral Director	8322 14th Street NW		2001	0		USA
	ë <u>ë</u> 5	Je l	11. Marital Status 12. Was Decedent Ever in U,S. 13. Was Armed Forces? 13. Was Decedent Ever in U,S. 14. Was Decedent Ever in U,S. 15. Was Decedent Ever in U,S. 16. Was Decedent Ever in U,S. 17. Was Decedent Ever in U,S. 18. Was Decedent Ever in	s Decedent of	Hispanic Origin	? (Specify Yes or No uerto Rican, etc.)	- 14. Race -	- American Indian, White, etc.
0	# # # # # # # # # # # # # # # # # # #	2	1 ☐ Never Merried 2 [X Married 1 ☐ Yes 2 [7] No			20110 1 110211, 0101,		
8	SE SE	Ď	3 ☐ Widowed 4 ☐ Divorced	Yes 2t∏ No	Specify:		Specify:	black
21215-0020	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or frems 23a or 28e-f show ent, the Medical Examiner must be nothing at	Completed	15. Decedent's Education 16a. Deceden	t's Usual Occu	pation	unk	16b. Kind of Busin	ness/Industry unk
5	7 2	ě	life. DO	d of work done NOT use retin	during most of ad)	working		
7	than o	Ē	Elementary/Secondary (0-12) College (1-4or 5+)		•			
	Pa A	ပိ	unk unk	1-	10 Mathodo	Name (First, Middle,	Maidan Sumamal	unk
2	tel H	Be	17. Fether's Name (First, Middle, Last)	unk	18. Mother's	Name (rirsi, Micole,	, Maiden Sumame)	unk
Maryland	Plan Hard	ဥ						
a	should and Men merke urnetic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A	Address (Stree	t and Number o	r Rural Route Numb	er, City or Town, St	ate, Zip Code)
Ž	and 2 alth e 27 is		Ethel Royster/spouse 1817 K	earney	Street	NE Washin	gton, DC	20018
φ	1 and Health sm 27 thar to	- 1	20a. Method of Disposition 20b. Place of Disposition	on (Name of		Date	20c. Location - Ci	ity or Town. State
Baltimore,	Pegas 1 and 2 should be filed within 72 hours after death with the Marylar nari of Health end Meniel Hygiene. nt: if item 27 is marked other than "naturel", or items 23a or 23e-f show iry or other traumatic event, the Medical Examiner must be nothed.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	ory or other pla	ace)			,
Ε	Pariti Pariti	- 1	4□Donation 5页Other (Specify) in state			1		
<del>≡</del>	permit. Depertu importa any inju		21. Signature of Funeral Service Licensee Ronald S. Wade, Director St	ame and Addr	ess of Facility	ond 655 ti	Dol+im	ore Street
m	perm Depe Impo any I						. Daitimo	le street
		$\dashv$	1 10 10 10 10 10 10 10 10 10 10 10 10 10	ltimore		21201		- Annual transfer
			23a. Pert1. Enter the disease or complications that caused the death. Do not enter t shock, or heart failure. List only one cause on each line.	ne mode or dy	ing, such as car	diac or respiratory a	rrest,	Approximate Interval Between
	Physician							Onset and Death
1	/Medical		Immediate Cause (Final disease or condition resulting in death)					2 Days
	Examiner		resulting in death)  a.  Due to (or es e consequer					- W
		e e	Due to (di es e consequer	ice oi).				
	per isc	clan/Medical Examiner	b					1
	eath certificate be executed attending physician end I for use es the bunal-trensit	xai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	nce of):				]
9	oe e cian ouria	<u> </u>	cause. Enter Underlying Ceuse (Disease or injury					
87	ate l hysi	흥	that initiated events resulting in death) Last  Due to (or as e consequent	nce of):				
3	Tiffic og p	§						
Box 68760,	andir use	2	d					
m		등	Part II. Other significent conditions contributing to death but not resulting in the under	duine course of	iven in Deat I	22h Did	tohenno uno contri	ibute to the cause of death?
o.	he d r the chec	× ×					/	THE TENED OF STREET
O.	The law requires that the data has been signed by the pege 2 should be detached	Completed by Phys	End Dage Renal Sweare	Dixe	258	10	Yes 21 No 3	☐ Probably 4 ☐ Unknown
Ś	es the igne	۱۵				_		
Ĕ	en s ould	8	C. I San Devel Diverse			24a. Was	an autopsy 2 rmed?	24b. Were autopsy findings available prior to
ပ္ထ	a by sh	e e	The Mage Rechair O'VERITE	3		_	200	completion of cause of death?
2	ne la L has	Ĕ				101	an as he	1 ☐ Yes 2 ☐ No
Vital Records,		ŭ	2- 111					1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
=======================================	Attending Physician: or death. ector: After this certific by the funerel director.	Be	25. Was case referred to medical examiner?	-		Death (Check only o		-
5	Physi this c rel dir	P.	1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient	3LI DON	4 ESTNUTSIN	ng Home 5 ☐ Resid	tence 6 □Other	(Specify)
_	ig Pl	Ë	27. Manner of Death  1 ☑ Natural 5 ☐ Pending (Month, Dey Year)  28e. Dete of Injury (28b. Time of Injury)	28c. Inju Wo	ry et ork?	28d. Describe i	how injury occurred	
₫	ath.	ğ			Yes 2 □ No			
<u>s</u>	octo	€	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street,	factory, office		28f. Location (S	Street and Number	or Rural Route Number,
Division	afte Dir	Certification:	4 Homicide building, etc. (Specify)			City or Tow	m, State)	
_	ours ours fillac	2	200 Codifice	accepted at the 4		lane and due to the		
	To the Hospital or Attending P within 24 hours after death.  To the Fureral Director: After i complataly filled in by tha funer	edicai	29a. Certifier  (Check only  (C	igation, in my	opinion, death o	ccurred at the time,	date and place, and	d due to the cause(s)
	To the I within 2 To the Complain	Ş Z	one) end manner stated.	l m- 11			and Date of	Manth Day Varia
	To To	-	29b. Signature and title of certifier	29C. Licen	se number	-	29d. Date signed (/	vionin, Day, Year)
		1	* Mulleull willer	(N)	019	70	oto sen	15 2005
		-	30. Name end address of person who completed cause of death (Item 23a) (Type, Prin	nt)			· ·	
			RANT A DEVODERUN 42031	Dies	ushu	W. Pol +	to a Tri	18 2025 18 M) 20781
			31. Date filed (Month, Day, Year) 32. Registrar's Signature			7: A N	7-1 500	4
	Sta	-	NOV 0 3 2005	20				
	Registra	"	NOV O S COOL STATES SO TO	-		<del></del>		

			For State Registrar	State of	Marylan		artment of H		nd Mental Hy	giene 05	35495
			1. Decedent's Name (First, Middle,	Last)					2. Date of De	ath	3. Time of Death
	Physici /Medic		Thomas Herbert	Schorah.	Sc.				Month October	Day Ye.	3.00 PM
2	Examin		4a. Facility Name (If not institution, g				4b. City, Town, or	Location of		4c. County of D	eath
			458 Lewis Lane	>			Havre o	de Ga	ace	Harf	ord
	Funeral			. Sex 7	. Age (In yrs.	last birthday)	If Under 1 Year		4 Hrs. 8. Date of Birt	h 9.	Birthplace (State or Foreign
	Director		215-09-5112	1,22 M 2□F	86	Yrs.	Months Days	Hours	Min. (Month, Da		Country)
	P		Usual Residence of Decedent								
	show	_	10a. State 10b. County	1		y, Town or Lo					10d. Inside City Limits 1
	98-f.	cto	Maryland Harf	o rel		Havre	de Grace				
	ith th	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of What	Country?
	23a		458 Lewis La	ne			2107			USA	
	er de	Funeral	11. Marital Status	12. Was Deced	es?	.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origi ın, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	- 14. Race - A Black, W	merican Indian, /hite, etc.
36	or I	by Fi	1 Never Married 2 Married	1 DYes 2		940	1 ☐ Yes 2 ☐ No	Specify:		Specify: L	stall a
21215-0036	within 72 hours after deeth with the Maryland ene. than 'natural', or items 23a or 28e-f show ts Madical Extrallier mast ke mollified at		3 Widowed 4 Divorced		es:/ / 10 - /	1	death Herel Cours	-11			
5	"nai	Completed	15. Decedent's (Specify only highest			(Give	tent's Usual Оссир kind of work doле с DO NOT use retired	during most	of working	16b. Kind of Busine	iss/industry
12	within	m d	Elementary/Secondary (0-12)	College (1-4	tor 5+)		arpente	*		Constru	etion
	be filed within 72 hours after deeth with the Marylan stal Hygiene. ad other than "natural; or Items 23a or 28e-f show a other than "natural; or Items 13a or 20e-f show event, it is Madical Examiliar interment to notified at		17. Father's Name (First, Middle, La	ist)			FCMC		's Name (First, Middle,	Maiden Sumame)	
Maryland	should be filed vand Mental Hygies marked other tournatic event, II	o Be	Herbert S						va Pass		
<u></u>	s 1 and 2 should be f Health and Mental Item 27 is marked t other treumatic eve	2	19a. Informant's Name/Relationship		_	19b. Mailir	ng Address (Street a		or Rural Route Number	ar. City or Town. Stat	e. Zip Code)
<b>S</b>	id 2 s ith ar 27 is 1 treu		Nancy Schoreh / D				-		niteford, Mi		.,,
	Heal Heal tem		20a. Method of Disposition	oug. I C	20b. F	lace of Dispo	sition (Name of		Date	20c. Location - City	or Town, State
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 It eny Injury or other tre		1 Burial 2 Cremation 3		ate	formetery, crei	natory or other place	(e)	0/31/05	Hansyes	MB
틒	urtme orten njury		<ul> <li>4 ♣ Donation 5 ☐ Other (Spe</li> <li>21. Signature of Fungral Service Lie</li> </ul>		Mileo	201714	Name and Address	ss of Facility	Analom Bills	Pasiale Tax	7.10
Ba	permi Depa Impo eny I		BE	5			Wallo and Addio.	7522	Analomy Giffs I	Drive STE	6
			23a. Part1. Enter the disease, or co	omplications that car	used the deat	h. Do not ent	er the mode of dvin		ardiac or respiratory ar		Approximate
	are error		shock, or heart failure. List or Immediate Cause (Final	nly one cause on each	ch line.	r 1-	N		- 4		Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a	ela	you	e icu	ncea	be Ca	incer	-
	Examiner			Due to (o	r as a conseq	uence or):					
		ē	Sequentially list conditions, if any, leading to immediate	b. — Due to (o	r as a conseq	uence of):					
./	nsit	II.	cause. Enter Underlying Cause (Disease or injury								
V	al-tra	Examiner	that initiated events resulting in death) Last	c Due to (o	r as a conseq	uence of):				-	
8760,	death certificate be executed e attending physicien and nd for use as the buriat-transit	dical		d							
.89	ificati phy as the	edic			_						
Вох	eath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco						23d. Date of	delivery
m	death a atte	cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregna	th 2 □ Feta nt at time of d		Ectopic pregnancy Other (specify)			Month	Day Year
0	the ry th sche	hys	9 Unknown	9∐ Unknov	vn						
۳.	requires that een signed b hould be deta	by P	Part II. Other significant condition	s contributing to dea	th but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use contribut	e to the cause of death?
b	n sig	d b							1 🗆 1	res 2,26 No 3 □	Probably 4 Unknown
Records,	> 00	Completed							24a. Was		autopsy findings available
	0 5 0	щc								rmed? death	
Vital	an: The ificate or, pag	Ö	25. Was case referred to medical					26 Place	1 ☐ Yes of Death (Check only o		'es 2□ No
5	Physicien: this certific ral director,	0 8	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	patient 2 🗆	ER/Outpatier	t 3 DOA Othe	95	sing Home 52 Resid		neciful
of	y Phys er this	n: T	27. Manner of Death	28a. Date of	Injury	28b. Time of	28c. Injun	/ at		now injury occurred	poony
on	Attending r death. ector: After by the fune	atlo	1 Natural 5 Pending 2 Accident investiga		Day Year)	Injury	Worl M 1 □	k? Yes 2∐N	0		
Division	Atte	ific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	289. Place o	f Injury - At ho	ome, farm, str	eet, factory, office				Rural Route Number,
Ö	a afte	Certification:	4 I Homede	Duilding	g, etc. (Specifi	y)			City or Tow	m, State)	
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer								place, and due to the		
	n 24 n 24 ne Fu	edical	(Check only 2 Medical Ex	and manne	stated.			pinion, deatr	occurred at the time,	date and place, and o	due to the cause(s)
	To the within 2. To the complet	2	29b. Signature and title of certifier	2 1	PRO	MILAS	CRI 29c. License	e number		29d. Date signed (Mo	onth, Day, Year)
			Minux	MI	7		D 33	3099		11/2/05	~
	141		30. Name and address of person wi	no completed cause	of death (Item	n 23a) (Type,	Print)				
_ 1	4'		700 S. W	won F	tue	, Ha	voe-de-l	your	MO	21078	
	Sta		31. Date filed (Month, Day, Year)	Sales	ar's Signa	ture	A				
	Registr	ar	NOV 0 3	2005	due.	B. A					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Oct Mary 23 Schauer 2005 J. 8:35 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Nursing Center Prince Frederick Calvert | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 24, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2₩F Yrs. Director 227-66-6320 65 Canada Usual Residence of Decedent with the Maryland 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits or 28a-1 show ir than "natural", or Items 23a or 28a-1 shoy Director 1 ☐ Yes 2√2 No MD Prince Frederick Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 125 Allnut Court #109 20678 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. flled within 72 hours after Hygiene. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) 11 waitress restaraunts permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumants 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Joseph Wadden Jean Tavenor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michell McGuffin/daughter 620 Walton Road Huntingtown, MD 20639 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dicensee 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 Ronald 655 W. Baltimore Street mar Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2/00 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed and Due to (or as a consequence of): physician a s the burial-P.O. Box 68760, Physician/Medical as the attending IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown ģ Dav Year 4 Pregnant at time of death 5 Other (specify) څ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by been si 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe page . this certificate 1 ☐ Yes 2 ☐ No 25 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: Certification: To 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) win completed cause of death (Item 23a) (Type, Print) 30. Name and address of (Suite 310 Prince Predertile MS 31. Date filed (Month, Day, Year) State 3 Registrar 2005 NOV 0

Division of Vital Records, P.O. Box 68760,		Baltimore, Marylan
tospital or Attending Physicien: The law requires that the death certificate be executed		permit. Pages 1 and 2 should be
I hours after death.		Department of Health and Mental
uneral Director: After this certificate has been signed by the attending physician and	sid ed m	Important: If item 27 Is marked o
1. Alternative de la company d		the state of the s

		,	_ 701	artment of Health and Ment <i>rtificate of Death</i>	Reg. No.	
ı	Physicia		1. Decedent's Name (First, Middle, Last)  John J. Stupi	l M	Date of Death Month Pay Year ober 29, 2005 3. Time of Death 5:00 P.	
-	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	_
	Examin	eı	Brightview Assisted Living	Catonsville	Baltimore	
П	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs. 8. Days   Hours   Min. (A	Date of Birth Month, Day, Year)  9. Birthplace (State or Foreign Country)	ign
	Director		210-01-2313 X 91 Yrs.		ril 19,1914 Pennsylvania	
	pur *	}	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation	10d. Inside City Limit	ts
	Aarylan I show	ō	MD Baltimore Catonsv		1 □ Yes 🏋	
	death with the Maryland ms 23a or 28e-f show Frans Le malled	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?	_
	3a or		912 S. Rolling Road	21228	United States of Americ	~ =
		Funerai		Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican		-
٥	72 hours after naturel', or ite		1 Never Married 2 Married 1 Nes 2 No	1 Yes 2 No Specify:		
0000	urel',	d by	Year or Dates:		Specify: White	
Ċ	"nat	lete	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry	
7	within ene.	Completed		nant Marines Seaman	Merchant Marines	
5	Hyg other ent,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (Firs	st, Middle, Maiden Surname)	
ā	Ald be Aenta rked tic ev	ToB	Joseph Stupi	Veronica V	/aller	
ary	should have some	_		ing Address (Street and Number or Rural Rou	-	
Ξ.	and Salth n 27 l				Street, Beaverdale, PA.159	€2
o e	of He		20a. Method of Disposition 1 ☐ State   20b. Place of Disposition   20b. Place of Disp	osition (Name of Date matory or other place)	20c. Location - City or Town, State	
E	Pagiment ment: lant:		`4 □Donation 5 □ Other (Specify) Lake View	Memorial Pk 11/03/	05 Sykesville, Maryland	
Da	permit Depart Import any in				g Byers Funeral Directors	
	GD = 6 0		23a. Part I. Enter the disease, or complications that caused the death. Do not en		ndallstown, Maryland 2113	3
			shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as caldiac of fest	Interval Between Onset and Death	
	Physician / /Medical	N	Immediate Cause (Final disease or condition resulting in death)		7 day	1
	Examiner		Due to (or as a consequence of):	fraullation.	3 years	-
Ļ		ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	fibrillatur	, , , , ,	_
	icate be executed physician and s the burial-transit	Examiner	that initiated events	1 astery d	15 ease	
Ď	be executed ician and burial-transi		resulting in death) Last Due to (or as a consequence of):			
09/90	tificate being physicias the bu	edicai	d			
	# Dog		IF FEMALE:			_
מ מ	leath certifii attending r	Physician/M		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery  Month Day Year	
o.	he de	ysic	1 Yes 2 No 9 Unknown	Outlet (specify)		
ř.	The law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use	y Ph	Part II. Dther significant conditions contributing to death but not resulting in the		23e. Did tobacco use contribute to the cause of death?	
cords	uires sign lid be	d by	Alzheimers dise	nse	1 Yes 2 No 3 Probably 4 Unknow	VΠ
5	s beer	Completed		2	24a. Was an 24b. Were autopsy findings availab	ole
Ž	The lar ate has page 2	omp		1	autopsy performed? prior to completion of cause of death?  1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No	1
VIE		0	25. Was case referred to medical	26. Place of Death (Che		
>	Q 5.	To B	examiner? 1   Yes   2   No   Hospital: 1   Inpatient   2   ER/Outpatie	nt 3 DOA Other: 4 Nursing Home	5 Residence 6 Other (Specify)	
0	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Injury	of 28c. Injury at 28d. D Work?	Describe how injury occurred	
UNISION	uttendii death. ctor: A y the fu	cati	2 Accident investigation	M 1 Yes 2 No		
$\leq$	or Att	Certification	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		ocation (Street and Number or Rural Route Number, City or Town, State)	
_]	e Hospital or 24 hours afte e Funeral Dii tetely filled in		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, dea	th accurred at the time, date and place, and di	fue to the cause(s) and manner as stated	
	24 ho 24 ho Fun etely	Medical	(Check only one)  2 Medicel Exeminer: On the basis of examination and/or in and manner stated.	in occurred at the time, date and place, and di evestigation, in my opinion, death occurred at t	the time, date and place, and due to the cause(s)	
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Me		29c. License number	29d. Date signed (Month, Day, Year)	_
	,- ,- 0		1/ This set us	D 27211	10/3//05	
	25		30. Name and address of person who completed cause of death (Item 23a) (Type Studen St	enge for El	dusburg, My 3/78	3
	Sta	te ar	31. Date filed (Month, Day, Year) 32. egistrar's Signature 32. egistrar's Signature	Siele !	, , ~	

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 1745 PM Sharpe October 27,2005 Kinston 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Nospital 11 saltimore HODKINS Johns If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number Months Days Hours 220.39.1403 10M 20F Usual Residence of Decedent 10a. State 10c. City Town or Location 10d. Inside Oity Limits 1 des 2 No ACTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code CHASE 21213 12. Was Decedent Ever in U.S. Armed Forces 1 | Yes 2 | No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cydan, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Marned 21 No 1 🗆 Yes Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STUDENT STUDENT 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) DOLES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route, Number, City or Town, State, Zip Code) KINSTON SHARDE JR. (HATHER KOAD 20a. Method of Disposition 1 12 Burial 2 Cremation 3 Removal from State Facility VAVOSTIN C. GREENE FUNEAR HM. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee ROAD BACTIMORE, MARYLAND 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Brain 4 days Anoxic MUNY Due to (or as a consequence of) ardio-respiratory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Asth Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 26. Place of Death (Check only one) Hospital: 1 ★Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 No 1 Tyes investigation 2 Accident

**Physician** /Medical Examiner use as the burial-transit The law requires that the death certificate be executed P.O. Box 68760, detached for the Division of Vital Records, ed bluods filled in by the funeral director, this ne Hospital or Attending Pl 24 hours after death. ne Funaral Director: After ti After within 2

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or 28a-f show

or items 23a

Director

Completed by Funeral

Be

2

Examiner

Physician/Medicai

þ

Completed

2

Certification:

Medicai

other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "nat any injury or other traumatic event, the Medical Dine.

Baltimore, Maryland 21215-0036

25. Was case referred to medical 27. Manner of Death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and the of certifier

29d. Date signed (Month, Day, Year)

MD 30. Nam and address of person who completed cause of death (Item 23a) (Type, Print)

2005

October 27,2005

State Registrar

MARCO CORRIDORE 31. Date filed (Month, Day, Year)

32. Registrar's Signature Coaste

MD

DHMH 17 Rev 1/2001

600 N. Wolfe

			For State Registrar	State of Marylan	-	artment of H			giene ()	5 3	35499
	* 4		Decedent's Name (First, Middle, La	nst)			-	2. Date of Dea Month	th Day	Year	3. Time of Death
200	Physicia /Medic	al	James	Henry Savoy,	ſr.			Oct 26	, 2005	(5)	6:04 P M
	Examine	er	fa. Facility Name (If not institution, give			4b. City, Town, or Clint	Location of Death		4c. County		orge's
			Southern Maryla  5. Social Security Number 6.3	Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	3	9. Birthpl	lace (State or Foreign
	<ul><li>Funeral</li><li>Director</li></ul>			XX <sup>M 2□ F</sup> 52	Yrs.	Months Days	Hours Min.	Sept 17	7,1953	Mary.	
	pu »		Usual Residence of Decedent  10a, State 10b, County	10c. Cit	y, Town or Lo	ncation				1	Od. Inside City Limits
	Aaryla f eho	ō	maryland Prince			er Marlbo	ro				1 ☐ Yes 2 ☐ No
	r 28a-	Director	10e. Street and Number		орре	10f. Zip Code			10g. Citizen of W		•
	th with		13300 Van Br	ady Road			772		United		
	tems	Funerai	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. 1	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecity Yes or No- Rican, etc.)		- America k, White, e	
36	irs aft	<u>م</u>	1 ☐ Never Mamed 2 ☐ Marned	1 □Yes 2 □ No If Yes, Give Year or Dates:		1□ Yes XX No	Specify:		Specify:	:	
9	72 hou	Completed	15. Decedent's E (Specify only highest gr		16a. Deced	dent's Usual Occup	ation during most of work	ing	16b. Kind of Bu	siness/Inc	lustry
2	ithin 7	mpie	Elementary/Secondary (0-12)	College (1-4or 5+)	Drive	DO NOT use retired	1)		Dont	f Tr	ansportatio
2	Hygia Hygia ther t		17. Father's Name (First, Middle, Las.	v	DIIVE	:T	18. Mother's Name	e (First, Middle,			msportation
lan	ld be ental ked o ic eve	To Be	James Henry Sa	voy, Sr.			Doro	thy Loui	se Butl	er	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiane. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show ery injury or other traumatic event. It a Medical Examinat must be notified at ODGE.		19a. Informant's Name/Relationship James H. Savoy				and Number or Run adly Rd,				
ē,	item 2	-	20a. Method of Disposition	20b. P	lace of Dispo emetery, crer	sition (Name of matory or other place	Nov 2,	Date	20c. Location -		wn, State
<u>ii</u>	Page nent c ant: if ury or		X □ Burial 2 □ Cremation 3 0 4 □ Donation 5 □ Other (Special	fy) Re	surrec	tion Cer	netery		Clinton		
Balt	Departr Departr imports eny inj		21. Signature of Funeral Service Line	mooas	0/40		<sup>ss of Facility</sup> Lee a Ferry Ro			nc 66	
*** 2	*		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the deat						,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	1548	MIC	BOX	DEL	-6A	LASEA	1	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	anic C	DEC ADIONA	Icc. V.A.	n Nico	ACC	YCAR
*	**	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq	uence of):	MC G	<b>W</b> UNCON	SCOR	C 010	110	(abl)
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C							
0,	cate be executed obly sicien and the burial-transit	Exa	resulting in death) Last	Due to (or as a conseq	uence of):						
8760,	physic the bu	dica	,	d							
9 X	es that the death certific igned by the attending p be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	incy_				23d. Date	e of delive	ery
Вох	death e atter d for u	iciar	in the past 12 months?	1 ☐Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		Ectopic pregnancy Other (specify)			Mor	ith	Day Year
0.	at the by the	hys	9 Unknown	9□ Unknown							
Division of Vital Records, P.O	es the	þ	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.			3 Prob	ne cause of death? ably 4 Unknown
los	aw require	Completed						24a. Was a		Vere autor	psy findings available inpletion of cause of
<u> </u>	sician: The law s certificete hes t lirector, page 2 s	EO						perfor	med? d	leath?	2 No
/ita	cian: ertific ector,	Be	25. Was case referred to medical examiner?	Hoppital		104	26. Place of Deat	h (Check only or	10)		
of C	Physician: r this certific ral director,	2	1 ☐ Yes 2 No  27. Manner of Death	<u> </u>	ER/Outpatier 28b. Time of		4   Nuising Ho		ence 6 Othe		<i>)</i>
on	Attending or death. ector: After by the funal	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Wor	k? Yes 2 □No		,,		
<u>Visi</u>	r Atter er dea rector by the	Certification:	3 ☐ Suicide 6 ☐ Could not lead of the determined		ome, farm, str	reet, factory, office		28f. Location (S City or Tow	treet and Numbern, State)	ar or Rura	l Route Number,
ō	urs afte rei Dir iled in										
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funaral director, page	Medicai		hysician: To the best of my kno miner: On the basis of examina and manner stated.							
	vithi To th	Σ	29b. Signature and title of certifier			29c. Licens	10001	C	29d. Date signed	1 3	/ 30
T			100			0	1874	2 0	JOBER	1 4	0,000
de			30. Name and address of person who	completed cause of death (Item	7 (C) F	Print)	18 (SW) 3	FA 11	AI DO	Fid	6, 2005 Ud. 2005
11	⊰ ∍ Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sight	ture	W.	C C C			-/-	
1. "	Registra	ar	NOV 0 3 20	US Marine Ar	1						

State of Maryland / Department of Health and Mental Hygiepe 05 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Andrew Albert Supik November 2, 2005 4:15 A M /Medical 4a. Facility Name (If not institution, give street and number)
Gilchrist Center 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Months Days Hours Min. 8. Date of Birth No (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 9. Birthplace (State or Foreign **Funeral** 1**X**M 2□F 219-01-0573 88 Yrs. Director Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentel Hygiene.
Important: if item 27 is marked other than "natural", or iteme 23s or 28a-f ehow with injury or other traumatic event, the Macical Examinat must be notified at once. 10a. State 10b County 10d. Inside City Limits Maryland N/A Baltimore City 1 X Yes 2 □ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3608 Mary Avenue 21206 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 ☐ No ff Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 4 yr s Elementary/Secondary (0-12) Housing Inspector City of Baltimore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert. Supik James Marie Benesch 19a. Informant's Name/Relationship (Type, Print) 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albert P. Supik - Son 117 Beech Bark Lane Towson, MD 21286 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 11/5/05 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Maryland 21214 Leonard J. Ruck, Inc. Haul 5305 Harford Rd. Varborh 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Renal weeks /Medical Due to (or as a consequence of) Examiner nighrosdowis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine signed by the ettending physicien and I be detached for use as the buriat-transit Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part if. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSPIC Hospital: 1 ☐ Yes 2 No 2 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; To the Hospitet or Attending within 24 hours after death. To the Funerel Director: After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and Itle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) St TOWSUN 000 21204 N. Chaples Maron 32 Registrar's Signature 31. Date filed (Month. ×3"2005 State Registrar